

MINISTRY OF HEALTH

Report of the
Maternity Services
Committee

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REPORT OF THE COMMITTEE ON MATERNITY SERVICES

Rt. Hon. DEREK WALKER-SMITH, T.D., Q.C., M.P.
Minister of Health.

SIR,

INTRODUCTION

1. We were appointed by the Minister of Health in April, 1956, with the following terms of reference:

“To review the present organisation of the maternity services in England and Wales, to consider what should be their content and to make recommendations.”

2. We held our first meeting in May, 1956, and since then have met forty-one times. After our first meeting we issued a general press notice indicating our terms of reference and inviting any person or organisation to submit to us their views in writing. We also invited a number of persons and organisations to submit written or oral evidence. Those who responded to these invitations are shown in Appendix I of our Report. We should like to take this opportunity of thanking all those who provided us with evidence.

3. Inevitably the most diverse views on the problems we were considering emerged from the evidence of our witnesses. In some cases we have referred specifically in the Report to the views of particular organisations on some particular matter: in others, we have generalised from the evidence we received.

4. Although our terms of reference applied only to England and Wales we considered it important to keep in touch throughout our deliberations with the work of the Scottish Maternity Services Review Committee, a Committee of the Scottish Health Services Council, which had been appointed in June, 1956, to consider the maternity services of Scotland in the context of the somewhat different circumstances of the health services in that country. To this end an observer from the Scottish Committee attended our meetings and we have had two joint meetings at which we have discussed with one another our main conclusions.

5. We have obtained information on certain aspects of the maternity services in a number of other countries including Australia, Canada, Denmark, Finland, Germany, Holland, New Zealand, Norway, Sweden, U.S.A. and the U.S.S.R. We should like to thank the persons and organisations in these countries who provided us with much useful information. Where we think that this information helps us we have referred to it in our Report. Quite frequently, however, we have found it difficult to make reliable comparisons because of the quite different social environment and traditions existing in other countries.

6. To place our work in perspective we have reproduced the recommendations of the Report of the Committee of Enquiry into the Cost of the National Health Service which form the background against which our Committee was appointed. Because the present maternity services under the National Health Service can be understood only in an historical context, we have provided a section dealing with the evolution of the maternity services in England and Wales. In Chapter 5, we have discussed the fundamental question of whether confinements should take place at home or in hospital. In later chapters we have discussed the organisation of the maternity services provided by the local health authorities, the general practitioners and the hospital authorities. This procedure, which we adopted as being on balance the most satisfactory, inevitably entails some duplication as many of the problems with which we deal are common to all three parts of the maternity service. We have indicated our conclusions and recommendations at the end of each chapter and these are summarised in Chapter 12 but for the convenience of the reader we have set out in the first chapter of our Report some of our more important decisions.

* * *

7. The Committee was shocked by the sudden death in October, 1957, of its Secretary, Mr. J. S. B. Butler, who had as much charmed the members with his personality as he had impressed them with his ability. Mr. J. T. Woodlock and Dr. Roma Chamberlain were appointed joint secretaries in November and had the exceedingly difficult task of picking up the threads at a time when the Committee had heard the greater part of the evidence given before it. In May, 1958, when the Committee was in the midst of drafting its Report, Mr. S. G. Mackenzie was appointed joint secretary in the place of Mr. Woodlock who had been promoted to become the Minister's Principal Private Secretary. It will be seen therefore that the two joint secretaries had a more than usually difficult task in assisting the Committee in its deliberations and in the drafting of this Report, and we would wish to express our deep appreciation of their untiring devotion to their work. Dr. Chamberlain's knowledge of the working of the National Health Service has been of the greatest assistance to us.

Finally we would wish to express our gratitude to Mr. S. J. Brighton who was in attendance throughout the whole period and carried out his duties with unflinching efficiency.

CHAPTER 1

THE WORK OF THE COMMITTEE

8. The Committee of Enquiry into the Cost of the National Health Service under the Chairmanship of Mr. C. W. Guillebaud which presented its Report in November 1955 recommended, in paragraph 639 of that Report, that the organisation of the maternity services under the National Health Service should be reviewed at an early date and suggested certain principles which might guide any such review.

9. It is as a direct result of this recommendation that we were appointed as a Committee to review the maternity services and it is worth recording in detail the comments of the Guillebaud Committee which led them to make their recommendation.

Paragraphs 631 to 639 of the Report of the Guillebaud Committee stated:

"MATERNITY AND CHILD WELFARE SERVICES

" 631. Many of our witnesses have told us that the division of the health services into three branches has had its most serious impact on the maternity and child welfare services. Responsibility for providing these services is now divided between the hospital authorities, local Executive Councils and local health authorities as follows:

- (i) The hospital authorities are responsible for the provision of hospital maternity beds and out-patient ante-natal and post-natal treatment in teaching and non-teaching hospitals.
- (ii) The local health authorities are responsible for the provision of a domiciliary midwifery service and ante-natal and post-natal clinics.
- (iii) The Executive Councils are responsible for making contracts with general practitioners who undertake to provide maternity medical services. These services involve the provision of prescribed ante-natal and post-natal care, with attendance at the confinement if necessary or if the doctor desires to be present.

A general practitioner obstetrician (i.e., a general practitioner who has been admitted to the obstetric list) may provide maternity medical services to any expectant mother; but a doctor not on the obstetric list may provide such services only for a woman on his own list.

- (iv) The position is further complicated by the arrangements for providing emergency medical aid for practising midwives. If a doctor is called by a midwife to an emergency under the medical aid scheme (i.e., to the confinement of a woman for whom he has not undertaken to provide maternity medical services) the doctor's fees are paid by the local health authority and not by the Executive Council.

" 632. Even within this general division of responsibility, there appear to be wide variations in the way the services are now being provided between one local authority's area and another. In some areas, the ante-natal clinics

are still manned by medical officers of the local authority, even though many of the expectant mothers attending the clinics may have booked a general practitioner to provide them with maternity medical services. In other areas, the medical services at the clinics are provided by general practitioners employed by the local health authority on a sessional basis. In others, the clinics may have ceased to provide a medical service at all and are concentrating increasingly on the development of the educational aspects of antenatal care, i.e., mothercraft (and even fathercraft), diet, hygiene, relaxation exercises, etc. Or again, the general practitioners may be providing 'clinic sessions' in their own surgeries, with the local authority midwives in attendance.

" 633. Our witnesses have expressed varying views about the drawbacks of this divided responsibility and its effect on the efficiency of the service. Some have pointed out that the maternity services have been made to work smoothly in some areas by close co-operation between the authorities and officers concerned; and that other areas could achieve the same results if only the people concerned had the will to co-operate. Others have suggested that the services should be brought under the undivided control either of the hospital authorities or the local health authorities. The Royal College of Obstetricians and Gynaecologists, for example, said that the present division 'tends to produce an atmosphere of competition not co-operation between the various components of the Service,' and recommended, among other things, the appointment of a statutory authority at regional level with executive powers to administer all the obstetric services. The College also recommended that:

- (a) The number of new admissions to the obstetric list should be related to the amount of domiciliary work to be done.
- (b) Means should be devised to ensure that the general practitioner obstetrician has time for his obstetric work. This may mean a restriction in the number of patients on his list.
- (c) All midwives should come under one employing authority and be subject to the same range of terms and conditions of service.

" 634. The witnesses who have favoured unified control of all the maternity services have pointed out that it would be possible by this means to secure a proper balance between the institutional and domiciliary confinements. There is disagreement, however, as to what should be a 'proper balance'. In 1952, the proportion of institutional confinements in England and Wales was 64.1 per cent, as compared with 58.4 per cent in 1949—the rise being due in the main to the fall in the birthrate itself; as the falling birthrate was not balanced by a reduction in the number of hospital maternity beds, the fluctuations in demand have been absorbed entirely by the local authority domiciliary services. We have been told that in some areas the proportion of institutional confinements may now exceed 80 per cent and yet in other areas may not exceed 45 per cent. It is noteworthy that these figures do not necessarily reflect the quality of the housing or the needs of the patients in the areas served. In areas with bad housing, etc., the proportion of hospital beds may be low; in areas with good housing the proportion may be high.

" 635. Some of our witnesses have suggested that hospital authorities should take a more strict view as to the 'medical needs' of patients applying for institutional confinement so that more beds may be made available for 'social cases', and so that in some areas the total number of maternity beds might be reduced and a proportion released for more

urgent purposes. There was a general feeling among these witnesses that in most areas 50 per cent would represent an adequate provision for hospital confinements—a view which is shared by the Ministry and has been enunciated in advice circulated to hospital authorities in England and Wales. The Royal College of Obstetricians and Gynaecologists, on the other hand, recommended that 'institutional confinement provides the maximum safety for mother and child, and therefore the ultimate aim should be to provide obstetric beds for all women who need or will accept institutional confinement'.

" 636. All our witnesses are in agreement that the proportion of expectant mothers attending local authority ante-natal clinics has fallen since the Appointed Day, in some areas quite substantially. This may have been due to the introduction of a maternity medical service, and the feeling on the part of the mother or the doctor that attendance at the local authority clinic, as well as the doctor's surgery, is not necessary. Attendances at the child welfare centres, on the other hand, have remained at a fairly constant level.

" 637. As there are medical issues and disagreements involved in these arguments which we as a Committee are not competent to judge, it is clearly out of the question for us to make any clear-cut pronouncement on this very complex issue. Our evidence does, however, indicate that the maternity services are in a state of some confusion, which must impair their usefulness, and which should not be allowed to continue. The present structure appears to represent a not very satisfactory compromise between the services which were in existence before the Appointed Day and the new maternity medical service which was introduced with the National Health Service. It seems to us that the time has now come for an appropriate body to review the whole of this field to find out precisely what services—medical and educational—are needed for mothers and young children and how they can best be provided through the framework of the National Health Service.

New thought is needed as to the proper role of the local authority clinic, the general practitioner and the hospital out-patient department in the provision of an efficient and comprehensive maternity service. Many local authority clinics, for example, are clearly changing in character. One of the reasons for their creation originally was no doubt the need to provide free medical advice for mothers who could not afford to pay for a doctor themselves. Under the National Health Service, however, free medical treatment is available to all; and it is significant that many local authority clinics are turning increasingly to the educational aspects of their work.

" 638. We do not consider it necessarily a bad thing that the organisation of the maternity services should have shown divergent trends in different areas, since the varied experience gained will be of great value in considering what should be the right lines of development in future; but we do think the stage has been reached when an authoritative inquiry should be set on foot to evaluate the work now being done and to arrive at some conclusions as to the most efficient forms of provision.

While it is not for us to prejudice the work of any committee that might be appointed to review the maternity services, we would suggest that the following principles might be borne in mind:

- (i) Preventive medicine begins with the expectant mother and her unborn child. It is vitally important that all expectant mothers should receive advice on mothercraft, diet, care of the unborn child, etc., and that

the responsibility for providing this advice should be clearly known to the authorities and officers concerned. The appropriate measures taken at this time of the mother's life will have a beneficial effect on the health (including the dental health) of future generations.

- (ii) As the numbers of women attending local authority ante-natal clinics have fallen since the Appointed Day, it may be that many women are now failing to receive the instruction they need in preventive health, and steps should be taken to make good this omission. If, for example, a woman has booked a doctor to provide maternity medical services, the doctor should be responsible either for providing *the whole* of the necessary instruction himself or (and this is most likely to apply in the majority of cases) advising the woman to attend the local authority clinic. The same obligation should lie on the hospital which has booked a maternity case, i.e., either to provide *the whole* of the appropriate instruction at the hospital or to arrange for its provision through the local authority clinics. As we understand it, there are at present only a few hospitals which provide training in mothercraft as well as medical ante-natal and post-natal treatment.
- (iii) The role of the local authority clinic may have changed in recent years, but it is just as important now under its new guise as it was under the old; and we should consider it a most retrograde step if the organisation of the maternity services under the National Health Service were to discourage mothers from attending the clinics, without at least providing equivalent services by some other means.

" 639. Accordingly, we recommend that the organisation of the maternity services under the National Health Service be reviewed at an early date, bearing in mind the principles outlined in (i) to (iii) above."

10. During our deliberations we have borne in mind these comments of the Guillebaud Committee. Perhaps we should say at this early stage of our Report that the evidence we received did not suggest that the maternity services were in a serious state of confusion: neither would we be inclined to say that the tripartite structure of the health services has of itself proved more detrimental to the efficiency of the maternity services than to that of the other branches of the health service.

11. Were it a question of reconstructing the personal health services as a whole, closely associated as they are with the work of the general practitioners and the hospitals, in the light of experience gained during the ten years since 1948, it is probable that the majority of us would suggest that a unified service, including of course a maternity service under the control of one authority, might be a desirable arrangement. Our deliberations have convinced us, however, that to suggest, at this stage, any drastic re-organisation of the maternity services alone, so as to place them under the sole control of either the hospital authorities, the local health authorities or of some quite new body, would be to create more problems than it would solve.

12. If we accept, as we are satisfied we must, that confinements will continue to take place both in hospitals and at home and that the existing tripartite system of administration must continue for some time to come, the real problem crystallises into one of co-operation and co-ordination between the individuals providing the various maternity services.

13. We believe that what is required at present is the retention of the existing tripartite structure of the maternity services but with a clearer definition of the responsibilities of the respective bodies providing the different parts of the service and the development—which should then become easier to achieve—of co-ordination and co-operation between them.

14. Our terms of reference include an assessment of the content of the maternity services and we have discussed this in some detail in our Report. In particular, in Chapter 4, we have outlined for the benefit of the lay reader, what we think should be the characteristics of a good maternity service of which we consider a very high standard of ante-natal care is perhaps the most important.

15. We have come to the conclusion that under present day conditions the practice of obstetrics requires the exercise of special skill beyond the normal competence of the general practitioner and a degree of experience that, with the present high institutional confinement rate, the average family doctor is unlikely to be able to maintain. We have therefore recommended the retention of an obstetric list and more uniform criteria which should be applied for admission to the list or retention on it.

16. Furthermore we have suggested that provision should be made over the country as a whole of a sufficient number of maternity beds to allow of an average of 70 per cent. institutional confinements, with the assumption that the normal period of stay in hospital after delivery will be ten days. We explain in our Report why we have come to these conclusions and indicate certain ways in which co-ordination can be developed.

CHAPTER 2

THE DEVELOPMENT OF THE MATERNITY SERVICE

17. Some knowledge of the historical background is essential for the proper evaluation of the present day midwifery service since many of its apparent inconsistencies have been the natural result, not of a single plan but of a gradual evolution.

18. Initially little interest was taken in midwifery by the medical profession except for the performance of destructive operations. The majority of midwives were untrained ignorant women but some were well respected and had received instruction from their senior colleagues. From 1567 licences to practise were granted by the Bishops but these licences mainly governed rules of conduct and were no guarantee of skill. During the 17th Century the obstetric forceps were introduced and the increasing interest in obstetrics taken by the doctor or "man-midwife" resulted in a bitter enmity between him and

his female competitor. The 18th Century saw the foundation of a few "lying-in hospitals" throughout the country but these took only a small proportion of the very poor. By the 19th Century a familiar pattern of a male doctor for the rich and a female midwife for the poor was well established. In 1886 the London Obstetrical Society, enquiring into the causes of infant mortality, found that in "villages and towns" between 30 per cent and 90 per cent of deliveries were conducted by midwives: the corresponding figure was 30 per cent to 50 per cent in the east end of London but in the west end it was only 2 per cent of deliveries.

19. There was no control over the training of either doctors or midwives. The "man-midwife" learnt his profession by apprenticeship or by attending courses of lectures. In 1845, the Society of Apothecaries included midwifery for the first time as a subject for its licentiatehip. Although the registration and control of the training of doctors began with the foundation of the General Medical Council in 1858, it was not until 1886 that midwifery became a necessary qualification. The training and registration of midwives followed much the same pattern. A chair of midwifery was instituted in Scotland in 1726 for the teaching of midwives but no attempt was made elsewhere to follow this example. It was not until 1872 that the London Obstetrical Society granted the first certificate of proficiency for midwives. After a long struggle, the first Midwives Act was passed in 1902 and the Central Midwives Board was founded to secure the training and certification of midwives in England and Wales. Thus by the beginning of the present century, the training and registration of both doctors and midwives had become established.

20. The Midwives Act, 1902, also entrusted the local supervision of midwives to County and County Borough Councils. In 1911 the National Insurance Act was passed providing for a cash maternity benefit for an insured woman or for the wife of an insured man but specifically stating that "medical benefit shall not include any right to medical treatment or attendance in respect of a confinement". These two Acts paved the way for the growth of the municipal midwifery services; the one by introducing for the first time a measure of control by local authorities over the midwifery service, and the other by divorcing obstetrics from the general medical care provided under the National Insurance Act.

21. In 1918 the Maternity and Child Welfare Act and the second Midwives Act were passed. The Maternity and Child Welfare Act required the larger local authorities to set up maternity and child welfare committees with power to attend to the health of expectant and nursing mothers and children under the age of five. The Local Government Board then prepared a model scheme and stated they would sanction and assist by grants of up to fifty per cent of approved expenditure. As a result ante-natal clinics, staffed usually by full-time medical officers, were set up all over the country. The Midwives Act, 1918, made it compulsory in an emergency for midwives to summon medical aid directly. This service was paid for by the local supervising authority who could claim from the patient. The midwives, however, were still either in private practice or working for an association, although the local authority could contribute towards the cost of each case. A number of voluntary hospitals also ran their own domiciliary service

in the districts surrounding their hospitals. Maternity care in hospital was provided in voluntary hospitals and in some beds in Poor Law institutions. It was not until 1936 that the third Midwives Act empowered local supervising authorities to employ full-time midwives.

22. Meanwhile in 1929 two important events occurred. Firstly, the College of Obstetricians and Gynaecologists (later the Royal College) was founded with powers to examine candidates and to confer diplomas, memberships and fellowships of the College. Secondly, the Local Government Act was passed, transferring the Poor Law institutions from the Boards of Guardians to the County and County Borough Councils, who were then able to staff and run their own hospital service including maternity hospitals. As a result the number of hospital confinements gradually increased, e.g., in 1927, 15 per cent of live births took place in institutions, in 1932, 24 per cent and in 1937, 39.7 per cent.

23. From 1936 local authorities had powers to provide a comprehensive midwifery service. This included full-time domiciliary midwives; ante-natal clinics staffed by medical officers with special experience in midwifery and supported by a consultant service; medical aid in case of emergency; obstetric "flying squads"; and municipal hospital accommodation. By 1946, some 50 per cent of all births took place in institutions and about 75 per cent of expectant mothers attended local authority ante-natal clinics. There were, however, wide variations in the standards of provision made by different local authorities.

24. In 1946 the National Health Service Act was passed and came into operation in 1948. The general plan of the Act was to divide the health services into three—the hospital services under Regional Hospital Boards and Boards of Governors; the domiciliary health services under local health authorities; and the general practitioner services under the Executive Councils. In order to fit into this general plan the maternity service was divided among the three branches of the Health Service.

25. Today the maternity service provided by the hospitals under Part II of the National Health Service Act includes beds in a maternity or general hospital together with the professional and technical resources necessary for the care of patients. Normally hospitals provide the ante-natal and post-natal care for their booked patients as well as an out-patient consultant service for others. In addition specialist domiciliary consultations and emergency obstetric services ("flying squads") are provided by the hospitals.

26. The maternity services provided by the local health authorities under Part III of the National Health Service Act include arrangements for the care of expectant and nursing mothers and the provision of an adequate number of certified midwives for attendance as midwives or maternity nurses on women in their own homes. These authorities are also responsible for the provision of the ambulance, health visitor and home help services, all of which play some part in the maternity service. Local health authorities provide ante-natal clinics staffed by medical officers and midwives, who carry out ante-natal and post-natal care for cases booked by the midwife for domiciliary

confinement, as well as interim ante-natal care for patients booked for hospital confinement, and for some women booked by general practitioners who ask the local health authority to do part of the care for them. In some areas the clinics may be used by general practitioners giving ante-natal care to patients for whom they have undertaken maternity medical services. The clinics arrange for health education, ante-natal exercises and relaxation classes and distribute welfare foods. In addition the local health authorities are responsible for the priority dental services for expectant and nursing mothers.

27. Maternity medical services are provided under Part IV of the National Health Service Act by general practitioners under contract with Executive Councils to provide general medical services. Doctors whose names are on the obstetric list (see paragraph 177) may provide, as general practitioner obstetricians, maternity medical services under the National Health Service to any patients who apply to them. General practitioners whose names are not on the obstetric list may provide maternity medical services under the National Health Service, only for patients who are on their general medical list. They may, however, elect not to provide such services. It is a requirement of the maternity medical services that a mother receives all proper and necessary treatment, including at least two examinations during the ante-natal period and a post-natal examination, together with such other care and attendance at the confinement as may be necessary. It is the normal practice for a doctor to ensure that the patient who books with him for home confinement also books a local authority midwife. Ante-natal care is carried out by both the doctor and the midwife but the majority of deliveries are conducted by midwives.

28. There are in fact many variations of this general pattern and later in our Report we explain in greater detail the existing arrangements for providing maternity care under the three branches of the Health Service. We there indicate some of the criticisms which have been levelled at these arrangements and discuss the various suggestions which have been made to devise a better system.

CHAPTER 3

SELECTED VITAL STATISTICS AND THE MATERNITY SERVICES IN CERTAIN COUNTRIES

29. Table I shows the number of live and still births, the live birth rates, the stillbirth rates, neo-natal, infant and maternal mortality rates, for England and Wales for the years 1931 to 1957. As can be seen the maternal mortality rate showed a rapid decline for the first twenty years covered by Table I but from about 1950 onwards it remained fairly stationary for some years. However, for the last three years there has been a further downward trend so that the rate of 0.39 maternal deaths (excluding abortions) per 1,000

Table I shows the number of live and still births, the live birth rates, the stillbirth rates, neo-natal, infant and maternal mortality rates for England and Wales for the years 1931 to 1957.

TABLE I

Year	Number of births (annual averages 1931-1950)		Live birth rate per 1,000 total population	Stillbirth rate per 1,000 total live and stillbirths	Deaths under four weeks per 1,000 live births— neo-natal death rate	Deaths under 1 year per 1,000 live births—infant mortality rate	Maternal mortality rate (excluding abortions) per 1,000 total live and stillbirths
	Live	Still					
1931-35 ...	604,573	25,826	15.0	41.0	31.4	61.9	3.56
1936-40 ...	608,330	24,336	14.7	38.5	29.2	55.3	2.70
1941-45 ...	669,269	21,032	15.9	30.5	26.0	49.8	1.80
1946-50 ...	780,933	19,228	18.0	24.0	21.1	36.3	0.95
1951 ...	677,529	15,985	15.4	23.0	18.8	29.7	0.66
1952 ...	673,735	15,636	15.3	22.7	18.3	27.6	0.59
1953 ...	684,372	15,681	15.4	22.4	17.7	26.8	0.64
1954 ...	673,651	16,200	15.1	23.5	17.7	25.4	0.59
1955 ...	667,811	15,829	15.0	23.2	17.3	24.9	0.54
1956 ...	700,335	16,405	15.6	22.9	16.8	23.7	0.46
1957 ...	723,381	16,615	16.1	22.5	16.5	23.1	0.39

total births for 1957 is the lowest figure so far recorded, representing 288 deaths in a total of 739,996 registered births. There were a further 61 maternal deaths from abortion during that year. As the actual number of maternal deaths is small in comparison with the total births the stillbirth and neo-natal death rates can provide a more sensitive guide to the standard of maternal care. The stillbirth rate has shown little change since 1948 and it will be noted that the rate for 1957 was 22.5 per 1,000 total births, which is almost the same as that for 1953 which was 22.4 per 1,000 total births, the lowest recorded stillbirth rate in England and Wales. The neo-natal mortality rate, i.e., death rate of children under 4 weeks per 1,000 live births, has fallen fairly steadily and 1957 had the lowest recorded rate which was 16.5 per 1,000 live births.

30. Table II shows the population and selected vital statistics of certain other countries compared with England and Wales. The difference between the rates for England and Wales shown in Tables I and II is because of the different basis of calculation used to give comparable figures with other countries. It is always difficult to make exact comparisons between one country and another because of differing standards. This table is, however, a useful guide to the variations between countries compared with the position in England and Wales.

We are greatly indebted to the General Register Office for providing us with the statistics quoted in the tables in this chapter and with those in Table III on page 26.

THE MATERNITY SERVICES IN CERTAIN OTHER COUNTRIES

31. Descriptions of the services available in a selection of other countries were obtained for us, either directly from the governments concerned or from authoritative persons who had visited them. While it would seem unnecessary to give a resumé of the work in each country, we wish to record certain points of which we took particular notice.

Australia

32. We were told that about 95 per cent of the confinements were conducted in hospital and that generally the doctor attended the delivery with the midwife. We were impressed by the success of the special efforts made in Australia and in New Zealand to prevent toxæmia.

New Zealand

33. We were informed that practically all the European patients were confined in hospital, and that this practice was being extended to the Maoris. The majority of general practitioners practised obstetrics and had access to most private and public hospitals. Since 1938 a free maternity service had been available. The average length of stay of maternity patients in public hospitals was 11 days. Reference was made to outbreaks of staphylococcal infection which had not become manifest until after the patient's discharge although the infection was contracted in hospital. We noted that in New Zealand eclampsia was a notifiable disease.

TABLE II
Populations and selected vital statistics of certain countries

	Estimated population (thousands), 1956	Live births, 1956	Birth rate per 1,000 population, 1956	Stillbirth rate per 1,000 live births, 1956	Neo-natal death rate [†] per 1,000 live births, 1956	Infant mortality rate per 1,000 live births, 1956	Maternal mortality rate (including abortion) per 1,000 live births, 1955
England and Wales ...	44,667 [‡]	700,335	15.7	23.4	16.8	23.7	0.7
Scotland [†] ...	5,145 [‡]	95,313	18.5	24.4	19.1	28.6	0.5
Australias [†] ...	9,428 [‡]	212,133 [‡]	22.5 [‡]	Not available	15.6 [‡]	21.7 [‡]	0.6
Canada ...	16,081 [‡] , [§]	450,739 [‡]	28.0 [‡]	15.5 [‡]	20.1 [‡]	31.9 [‡]	0.8 [‡]
New Zealand [†] ...	2,178 [‡]	56,593	26.0	17.0 [‡]	13.4 [‡]	} 23.2	0.4
Denmark ...	4,466 [‡] , [§]	76,725 [‡]	17.2 [‡]	20.1 [‡]	19.9 [‡]		0.5
Netherlands ...	10,888 [‡]	231,204 [‡]	21.2 [‡]	17.2 [‡]	13.0 [‡]	24.9 [‡]	0.6
Sweden ...	7,316 [‡]	108,054 [‡]	14.8 [‡]	16.4 [‡]	13.0	19.0 [‡]	0.5
U.S.A. ...	168,174 [‡]	4,168,000 [‡]	24.9 [‡]	13.5 [‡]	18.8	17.0 [‡]	0.5
						26.0 [‡] ^{§§}	0.5

* Provisional

† Based on deaths under four weeks, except in Denmark where the base is calendar months.

‡ Data known to be based on year of registration of births and deaths rather than on year of occurrence.

§ Home population, i.e. population of all types actually in the country.

§ Excludes full-blooded aborigines, estimated at 46,638 in June, 1947.

§ De jure population.

§ Census population, 1956.

§ Including data for Campbell and Kermadec Islands (population 19 at 1951 Census, area 148 square kilometres), but excluding the other minor islands which are uninhabited. Excluding armed forces overseas, numbering 2,162 at 1956 Census.

§ Excluding Faeroe Islands and Greenland.

§ De jure population, excluding civilian citizens of continental United States absent from country for extended periods of time.

§ Including events to Canadian residents temporarily in the United States, but excluding events to U.S. residents temporarily in Canada.

§ Including events occurring outside country if one or both parents are included in a Netherlands population register.

§ European population.

§ Maori population.

§ 1955 figure.

§ Including deaths of Netherlands residents outside country it listed in a Netherlands population register.

§ Computed on births estimated from a 50 per cent sample.

§ Excluding Yakoo and North-West Territory.

Canada

34. The services in Canada seemed to be very similar to those in the United States. We were informed that the average length of stay in hospital was one week. Generally the physicians who provided ante-natal care also delivered the patients, except for those admitted to general hospitals where any of the resident physicians attended the confinement.

United States of America

35. We understood that with the exception of a few of the southern States, the bulk of the deliveries were conducted by physicians in hospital. The average length of stay in New York was short, 6.3 days in 1951 and 5.6 days in 1957, but these figures included women who had been admitted for false labour, ante-natal care, etc. In 1951 the normal stay after a live birth was about 7 days which probably gives a better guide. Our impression was that the length of stay was governed to a large extent by the high cost to the patient of hospital care. Little or no nursing facilities seem to have been provided in the home for mothers after discharge from hospital.

Holland

36. One member of our Committee was able to visit Holland and he reported that 78 per cent of confinements took place at home. The patient might make arrangements for her maternity care either with a general practitioner, who was able to charge her a fee as a private patient, or, under the insurance system, with a specialist who provided ante-natal and post-natal care and a midwife who conducted the delivery. Under the second system, medical aid, if necessary, was provided by a general practitioner whose fees were paid by the State. A feature peculiar to Holland was the system of maternity helps known as Maternity Aids provided by the State and paid for by the patient according to her means, to which we refer again later in this Report. The maternity services in Holland are of particular interest in view of the high domiciliary confinement rate, the low maternal death rate, and the high incidence of breast feeding (95 per cent of babies were breast fed until the 3rd month). We consider, however, that in assessing the success of this system, the special cultural and social circumstances of Holland, its semi-rural development and the sense of vocation of the Maternity Aids must be taken into account.

Scandinavian Countries

37. We understand that hospital confinement rates varied from 40 per cent in Denmark to 96 per cent in Sweden. In Norway and Finland the institutional rates were high. In Sweden the average length of stay of maternity patients in hospitals was 7 to 8 days. In Denmark some very short stay general practitioner homes had been built to which the mothers were admitted for delivery only, but Danish opinion seemed to be divided about the merits of this scheme. In Finland it was the practice not to pay a maternity grant unless the patient registered early in pregnancy.

Union of Soviet Socialist Republics

38. The maternity service in Russia provides a very high institutional rate in the towns and about 50 per cent in rural areas. There appeared to be

about twice the number of doctors per head of population as in the United Kingdom, but they were graded according to their various levels of training which were not comparable with those in this country. Expectant mothers were seen monthly by consultants but it was not known whether the term "consultant" had the same meaning as in this country.

CHAPTER 4

THE CONTENT OF A MATERNITY SERVICE

39. The National Health Service Act, 1946, aims at providing a comprehensive maternity service and in order to appreciate how best this can be achieved, it would seem appropriate to review here the requirements for a good standard of maternal care.

40. The success of a maternity service is to be measured by the saving of life, by the improvement in the standard of health of mothers and babies, and also by the extent to which it can diminish the fears, difficulties and discomforts which, in some measure, have to be faced by every woman who embarks on motherhood. By these tests we cannot fail to be encouraged by the improvements which have taken place in the past 20 years, but from the evidence we have received we believe that still further improvements are possible in the light of present-day medical knowledge and with the existing skills and resources at our disposal. Quite apart from advances in medical knowledge, we believe that greater efficiency in the technical and administrative fields, and the better deployment of resources which already exist, could perhaps save the lives of one or two more mothers out of every 10,000, and of one or two more babies out of every 1,000, and bring to every mother some increased comfort, security and peace of mind for the tasks she has to face.

41. To this end we outline for the guidance of the lay reader a pattern of maternal care which in the light of present-day knowledge, would, we believe from the evidence we have received, be generally acceptable.

42. We wish to commend the advice given by the Standing Maternity and Midwifery Advisory Committee in their memorandum on "Ante-natal Care Related to Toxaemia" which we publish as Appendix II to our Report. We wish to stress the importance of regular periodical examinations and the need to ensure that the patient attends regularly. The frequency of these examinations should follow the recognised practice of monthly examinations to the 28th week, fortnightly examinations until the 36th week and then weekly until the patient's confinement. Any additional examinations should be given as frequently as the patient's condition requires.

43. It is the duty of the doctor to ensure that the expectant mother is told of all the facilities available for her ante-natal care and confinement and of the various benefits which are provided for her.

44. Health education and training in mothercraft are important. Tuition should be given individually during the routine examinations, and in classes

or group discussion at a time and place convenient for most mothers. The gas and air, trileone or other analgesic apparatus should be demonstrated to allow the mother to become familiar with its use should analgesia be required during labour. At any stage in pregnancy the services of a home help should be available if it becomes necessary for the expectant mother to have extra rest in bed or to be admitted as an emergency to hospital, so that she is not prevented by her home commitments from receiving proper care. The psychological requirements of the mother should not be forgotten and time and opportunity should be given to allow her to discuss her problems with her doctor and her midwife.

45. It is generally agreed that, ideally, one person in whom the mother has confidence should be responsible personally for both her ante-natal care and her delivery but since this is not always possible to achieve in hospital, opportunity should be given during pregnancy to allow her to become acquainted with the persons who will be attending her during delivery. If the patient wishes, provision should also be made to enable her to visit the labour and lying-in wards. Full instruction should be given to mothers who are to be delivered at home on the preparation of a room for labour and the equipment which will be needed. A sterile maternity pack should be provided. If needed the services of a home help should be available for the lying-in period. Care should be taken to ensure that the patient is aware of the symptoms of the onset of labour. She should know where and when to summon the ambulance if she is booked for hospital confinement or how to obtain the help of the domiciliary midwife for a home confinement, whether by day or by night.

46. During labour a mother should be assured of receiving the help of a midwife and a doctor. Should it become necessary for the midwife to call for medical aid, this help, should, as far as possible, be given by the doctor who has been responsible for the mother's ante-natal care. If any sudden emergency arises, either the doctor or the midwife should be able to summon immediate help from an experienced obstetrician and anaesthetist with all the equipment necessary for resuscitation, including blood transfusion. The help of a paediatrician should be easily obtainable should the baby require any special treatment. A properly equipped premature baby unit should be available. Special equipment may be necessary for the transfer of premature infants to these units, although it is always more desirable for the sake of the infant to admit the mother in premature labour. In hospital or at home, a simple and effective method of summoning help should be provided in the labour room but this does not mean that a mother should be left alone for long periods. In hospital her husband or a relation should be allowed to stay with her, if she wishes it, at least during the first stage of labour. If this is not possible, an attendant should be near at hand to encourage and help her during this difficult period.

47. After confinement skilled nursing supported by medical attention should be provided and arrangements should be made to enable every woman to get adequate rest. Post-natal exercises to assist her muscles to return to normal as soon as possible should not be neglected. Practical instruction on the management of her baby and its feeding should always be given and welfare foods and iron preparations should be available.

48. About six weeks after the birth of her baby, a medical and gynaecological examination should be given and any treatment arranged with the help of consultant services if necessary. The post-natal period may be one of strain to the mother due to extra work, breast feeding, residual anaemia, and the difficulties involved in the readjustment of family life. It is therefore important that the midwife, health visitor or doctor as may be appropriate should be available to help the mother with any problem which may arise.

49. The needs of a mother during pregnancy, labour and the puerperium have been outlined here and, regardless of where and by whom she is confined, it is essential that she should receive the full benefit of good maternity care.

CHAPTER 5

THE PLACE OF CONFINEMENT: HOME OR HOSPITAL?

50. During the last 25 years there has been a progressive increase in the proportion of confinements taking place in hospitals or maternity homes. The rate of increase accelerated during and immediately after the war, particularly in rural areas. The proportion of births taking place in institutions in England and Wales rose from 39.7 per cent in 1937 to 52.8 per cent in 1947 and in 1957 reached 64.6 per cent or 476,783 out of a total of 737,704 notified births. Evidence from other countries also shows the same general trend, although the proportion of hospital confinements differs considerably between one country and another: Australia, New Zealand, Sweden and the U.S.A. have almost a 100 per cent institutional confinement rate while in Holland about 78 per cent of all births take place at home.

51. In this country the proportion of births taking place in institutions varies, between different areas, from nearly 100 per cent in the Isles of Scilly to about 33 per cent in Middlesbrough, with, in general, the larger towns showing the higher proportions. (See Appendix III.)

The evidence we received

52. We have received much evidence regarding the factors which influence a woman's decision whether to have her baby at home or in hospital. Everyone was agreed that hospital provision should be made for all cases in which there were medical or social factors which would make a home confinement undesirable and for women with an abnormal fear of being confined elsewhere than in hospital. Many of our witnesses, including representatives from women's organisations, Regional Hospital Boards and the Royal College of Obstetricians and Gynaecologists said that there was in most areas an unsatisfied demand for hospital confinement. They considered that active steps should be taken to encourage all women to have their babies in hospital but accepting the fact that some women would still wish to have their babies at home, they thought that better arrangements should be made for dealing with domiciliary emergencies. They considered that beds should be

provided for all women who wished to be confined in hospital even if this meant that practically all confinements took place in hospital. There were many reasons why women generally preferred to have their babies in hospital. One reason was that it was thought to be safer. Housing conditions clearly were an important factor, not only for slum dwellers but also for mothers living in small houses on new housing estates who had little space to spare and who were often living far from the relations or friends to whom they would previously have looked for help. Hospital confinement was considered less disruptive of home life, especially if there were several children in the family to be looked after. Mothers were said to get a complete rest in hospital and there was a widely held opinion that hospital confinement was cheaper for the mothers although it was thought that it was probably more expensive to public funds. In some areas the demand for hospital confinement was increased by expectant mothers moving from one area to another and by immigrants from overseas.

53. The Royal College of Obstetricians and Gynaecologists emphasised that in their opinion hospital confinement offered maximum safety for the mother and the baby. They pointed out that the need for the Emergency Obstetric Service ("flying squad") in 1 per cent to 2 per cent of home confinements, even where selection had been most careful, emphasised that emergencies did occur in the home. The Ministry of Health's "Report on Confidential Enquiries into Maternal Deaths in England and Wales 1952-1954" suggested that some fatalities might have been prevented if the women had been confined in hospital instead of at home.

54. Many of our witnesses, however, were concerned about the dangers of infection to the mother and baby and some of them suggested that the risk of infection was much greater in a hospital confinement than in a confinement at home. Fears were expressed that infections in hospital would become more serious in the future. Some of our witnesses pointed out that beds in general hospitals were provided for sick persons who could not properly be looked after in their own homes. They said that beds in maternity hospitals should certainly be provided for medical and social cases but not to suit the convenience or preferences of women who could safely be delivered at home when there was a pressing demand for beds for other purposes.

55. Nearly all our witnesses recognised that some women, perhaps between 10 per cent and 20 per cent, preferred to have their babies at home and in fact many witnesses, including those from women's organisations, the Royal College of Midwives, the British Medical Association and the Association of Municipal Corporations, stated that there were important physical and psychological advantages in the normal confinement taking place at home. Some witnesses thought that in women having their first babies the fear of labour was diminished in familiar surroundings, and the presence and sympathy of relations, particularly the mother, was of great help. The College of General Practitioners said that many mothers would prefer home confinement if assured of its safety. It was said that in the home the relationship between the mother and the baby was developed better, breast feeding could be more readily maintained and the risk of infection to the baby was reduced to a minimum. Other witnesses thought that confinement at home was less disruptive of family life than when confinement took place in hospital

so that the children were deprived of their mother's presence. It was considered that the noise and activity in a hospital resulted in less rest for the mother. She might be delivered by staff who had had no contact with her during her pregnancy and who might be less experienced than the domiciliary midwives. Several witnesses, including representatives of women's organisations, were of the opinion that the increased demand for hospital confinement was largely due to the inter-war propaganda on maternal mortality and suggested that the maternal death rate was now so low, and the advantages of domiciliary confinement so great, that active propaganda should be organised to encourage women to have their babies at home if medical and social reasons permitted.

56. There was a feeling that continuity of care was more readily achieved when a confinement took place at home. The mother had the doctor of her choice, the family link with the general practitioner was strengthened and the domiciliary midwife, becoming a familiar friend of the whole family, had a better understanding of the mother and her background than could a hospital midwife. Several of our local authority witnesses said that a woman having her baby at home more frequently received mothercraft and health education at the local health authority clinic than did a patient booked for hospital confinement at the hospital clinic. The importance in home confinements of satisfactory domestic conditions and of adequate and reliable home helps where required was frequently stressed.

Our views

57. We are in agreement with our witnesses that hospital confinement is essential for all women with medical or social need. We have considered whether the possibility of an unsuspected complication in the apparently normal case would justify the provision of hospital beds for all confinements as in Sweden and Australia. Social conditions and customs are different in those countries and we do not believe that it is likely that all women in this country would wish to have their babies in hospital. We believe that the advantages of home confinement for the apparently normal case probably outweigh the very slight risk of unforeseen complications.

58. We cannot ignore the indications that a new movement towards home confinement, particularly among middle class women having their second children, has gained ground in recent years. This is in contrast to the popular demand for hospital or nursing home confinement in the years between the wars. The recent change is not so apparent where there are general practitioner maternity units in which the woman can be attended by her own doctor. We should not like to over-emphasise this trend, however, because we are aware that in many areas there is still an unsatisfied demand for hospital beds.

59. We have borne in mind the practical aspects of the problem. There is at the present time a serious shortage of practising midwives and the shortage is more acute in the hospitals than in the domiciliary service. Even if the financial resources were available to provide hospital beds for all confinements there would appear to be little prospect of finding enough midwives to staff them. In any case, we doubt whether the provision of maternity beds for all confinements could be justified as the need for hospital facilities for other classes of patients may be more urgent.

60. Taking all these factors into consideration we have concluded that although the hospital maternity service should be expanded, it is of vital importance that a good domiciliary maternity service should be maintained. We consider it is essential that more uniformly high standards of ante-natal care should be assured and a more careful selection of patients should be made for domiciliary confinements and for admission to hospital.

SELECTION OF PATIENTS FOR ADMISSION TO HOSPITAL

The advice of the Standing Maternity and Midwifery Advisory Committee

61. In 1951 a memorandum was sent by the Ministry of Health to hospital authorities embodying the advice the Minister had received from the Standing Maternity and Midwifery Advisory Committee about the selection of patients for hospital confinement. (See Appendix IV.) It said that the proportion of hospital to domiciliary confinements had not been determined on medical grounds alone but partly by long standing custom and partly by the availability of beds for normal confinements. Housing had had some effect on the demand but in some areas with relatively good housing there were 80 per cent or more hospital confinements while in others with much worse housing only 30 per cent. In most areas there was still a greater demand for beds than the hospitals could meet. It was conceded that more beds would be needed in some areas but most areas would have enough maternity beds provided a proper selection was made. Without selection more beds would have to be provided at the expense of other pressing needs. It was suggested that priority should be accorded to all cases in which there were (a) medical or obstetric reasons in the widest sense of these terms and (b) adverse social conditions, especially bad housing. It was considered that (a) should include most multiparae who had had four or more children but should not be regarded as necessarily including all primigravidae, although a large proportion of the latter should be admitted. It was not possible to define criteria as to what were adverse social conditions; these were not solely a matter of housing. Local custom and the availability of attendance were important factors. The memorandum recommended that social factors should be assessed by the local health authority.

Report on Confidential Enquiries into Maternal Deaths

62. According to the "Report on Confidential Enquiries into Maternal Deaths in England and Wales 1952-1954" avoidable factors were present in 40 per cent of deaths directly due to pregnancy and childbirth, excluding abortion. It had not been possible to make a strict comparison between the occurrence of avoidable factors in domiciliary and hospital confinements but the Report pointed out that the greatest saving of life could be brought about by a reduction of avoidable factors in domiciliary care. While errors in the domiciliary service were mainly errors of omission those in the hospital service were mainly of commission.

63. The Report said that while there was nothing to suggest that all women should be confined in hospital there was strong evidence of the wisdom of arranging hospital care for all women over the age of 35 years, for primigravidae over the age of 30 years, for women who had already borne four or more children, and for cases of multiple pregnancy. These

groups accounted for approximately 22 per cent of all births. In addition hospital confinement was necessary for cases in which abnormality arose or had been present in a previous pregnancy. The majority, though not all, of such cases were likely to fall into one or other of the groups mentioned. The Report recognised the claim on hospital beds for primigravidae under 30 years old (32 per cent of all births) but pointed out that the mortality figures in the Report emphasised the higher claims of the other groups.

The evidence we received

64. Other recent investigations have indicated that certain groups of mothers, including primigravidae over the age of 30 and multigravidae over the age of 40, were more liable to have stillbirths and neo-natal deaths. There was also an increasing danger after the fourth confinement, in multiple pregnancies, and in patients with a previous history of stillbirths and neo-natal deaths.

65. Evidence received by us was broadly in agreement with the recommendations of the Standing Maternity and Midwifery Advisory Committee, referred to in paragraph 61 above. Many of our witnesses considered that the present method of selecting patients for hospital confinement was unsatisfactory and our evidence showed that it varied throughout the country. Some hospitals were alleged to accept patients for hospital confinement solely on the basis of "first come, first served", irrespective of whether this could be justified by medical or social reasons. Hospitals often failed to consult local health authorities regarding the social needs of patients whose medical condition would not justify confinement in hospital. Some of our witnesses suggested that the selection of patients with social reasons for admission to hospital should be made by the general practitioner, but the majority considered that this selection should be the responsibility of the local health authority. We were told of some hospitals in which beds were overbooked with normal cases and that patients with social need or those with important medical reasons for hospital confinement found difficulty in getting a bed.

66. Although one witness suggested that hospital beds should be provided for all women other than some 10 per cent who would prefer home confinement, the recommendations of our witnesses on the priority groups of patients for whom hospital provision should be made varied widely and included the following:—all primigravidae, or only those over 30; multiparae with four or more, or five or more children; multiparae over the age of 35 or 40; multiple pregnancies and patients with social reasons for hospital confinement. Some witnesses considered that a 50 per cent hospital confinement rate would cover adequately all priority groups.

67. Difference of opinion on the question of whether all primigravidae, who account for 40 per cent of all confinements, should be admitted to hospital in the absence of definite medical indications resulted in a very wide variation in the total number of maternity beds considered necessary. The arguments advanced for admitting all primigravidae were that in first pregnancies some abnormalities and complications of labour could not be foreseen during pregnancy and the admission of all primigravidae was therefore a precautionary measure which some felt to be necessary. The same considerations did not apply to women having their second, third or fourth confinement, the course of which would be more easily predictable from previous experience.

68. We were particularly interested to receive evidence regarding the experience of hospital authorities in assessing the number of beds required on medical and social grounds. One Regional Hospital Board had reached the conclusion, after a careful survey, that in order to provide beds for all abnormal cases, including premature labour and multiple births, all primigravidae not already included, all those women with the fifth or subsequent child, and all other women who needed a bed for social reasons, the Board would have had to make provision for 65 per cent of all confinements in their area. Another Regional Hospital Board, after a similar investigation, concluded that beds for 70 per cent of all confinements would have met all requirements on medical and social grounds. This would have included all primigravidae, all women over the age of 35 years, all women with toxæmia however slight, all women with five or more children, multiple pregnancies, all other emergencies and complications and all women with adverse social conditions.

Our views

69. In our view the local health authority is the appropriate authority to determine whether social reasons make a home confinement undesirable and they should always be consulted by hospital authorities before a decision is made to book a patient solely on social grounds. Local health authorities should inform hospitals in writing of the details of the social reasons which make a home confinement undesirable, so that the hospital authorities have some yardstick by which to assess priority should early discharge of some patients become necessary.

70. We have no doubt that the need for the provision of maternity beds will vary quite considerably from area to area having regard to standards of general health, housing and social conditions, local custom and the standard of the domiciliary services. We are not therefore in a position to say for what percentage of confinements hospital provision should be made in any particular area but we have come to the conclusion that taking the country as a whole a provision of maternity lying-in beds for 70 per cent of all confinements would be adequate to provide for the following patients:—those in whom there is an abnormality or in whom an abnormality might be anticipated (this would include mothers with four or more children and all those over the age of 35); those who require admission on social grounds (including social emergencies); all primigravidae not included in the above groups; and those patients booked for home confinement who require emergency admission for confinement for medical reasons. The extent to which beds can be provided for all primigravidae can be decided only in the light of general local needs and circumstances. We recommend that provision of maternity lying-in beds should be made on this basis which we consider should meet the needs of all women in whose case the balance of advantage appeared to favour confinement in hospital. We have assumed that the remaining 30 per cent of confinements would take place at home.

71. In paragraphs 230 and 231 we have discussed the need for the provision of ante-natal beds. Our information indicates that some 20 to 25 per cent of all expectant mothers require to be admitted to hospital for ante-natal treatment. Our estimate of a 70 per cent hospital confinement

rate includes the provision of lying-in beds for those patients but does not include those beds which will also be required for their ante-natal treatment. Very few of the patients, booked for home confinement, who are admitted to hospital for emergency ante-natal treatment are subsequently discharged for delivery at home. As our estimate of 70 per cent includes patients booked for domiciliary confinements who are admitted in labour as emergencies, it can be assumed for practical purposes that provision of lying-in beds for all patients needing ante-natal treatment will have already been made. We recommend that hospital authorities should provide ante-natal beds for 20 per cent to 25 per cent of all confinements in their area. We would emphasise that in our view it is extremely important that these ante-natal beds should be provided as a matter of priority. These beds should be in addition to the beds needed for confinement and lying-in and they should be reserved solely for patients requiring ante-natal treatment.

LENGTH OF STAY IN HOSPITAL

72. The present average proportion of hospital confinements over the country as a whole is some 65 per cent of all births. If our view is accepted that provision will require to be made for some 70 per cent of confinements in hospital it is necessary to consider by what means this increase should be achieved. The two most obvious ways are firstly, by reducing the length of stay in hospital of a mother after delivery thus making greater use of existing facilities and secondly, by increasing where necessary the number of available maternity beds. We have given some thought to both of these methods and have heard evidence from several witnesses.

73. At the time of the Guillebaud Report the birth rate was falling but since then it has been rising. One of the methods by which hospitals have been enabled to meet the increasing demand for hospital confinement without an increase in the number of staffed maternity beds, has been by a general reduction in the length of stay in hospital. At present the length of stay after normal delivery varies very considerably between hospitals and between different areas of the country. The variations in the length of stay are in fact so great as to cast doubt upon the significance of any average that could be quoted.

74. There are no official regulations concerning the length of stay for a mother in hospital. The "lying-in period" is prescribed by the Rules of the Central Midwives Board and is defined in these Rules as "a period being not less than 14 days nor more than 28 days after the end of the labour during which the continued attendance of a midwife on the mother and infant is requisite". In a memorandum sent by the Ministry of Health in 1953 to hospital authorities clarifying the meaning of the term "lying-in period" as defined in the Rules of the Central Midwives Board, it was made clear that this was not necessarily the same as the period the mother spent in hospital. It was stated that the period during which a mother and child should be kept as in-patients in hospital or a maternity home after confinement depended mainly upon clinical considerations. The length of stay in hospital would vary according to the circumstances of the case and in the Minister's view it should be not less than 10 days unless there were special reasons in particular cases for early discharge. As the time a woman spent in hospital after delivery was not necessarily co-extensive with the

lying-in period it followed that in some cases the mother or child would require the services of a midwife after discharge from hospital. The memorandum went on to ask hospital authorities to ensure (a) that maternity cases were not discharged until they were ready to resume home life (and in this connection the nature of the home was to be taken into account) and not, except in very special circumstances, before the tenth day; and (b) that information needed by the family doctor and by the Medical Officer of Health for arranging domiciliary care by a midwife during the remainder of the lying-in period, was given regularly and promptly with the knowledge and agreement of the patient.

75. The Central Midwives Board are primarily concerned with the length of the lying-in period in relation to its effect on the training of pupil midwives. Before approving a school for this purpose the Board require to be assured that the pupil midwife shall have satisfactory experience in nursing the mother during the lying-in period. This experience is not considered satisfactory where systematic early discharge from hospital is practised. The Board does not now, however, insist on the requisite experience of nursing in the lying-in period extending over the full fourteen days, which is at present the minimum length of the lying-in period prescribed by their Rules, and accepts the common practice of discharge on the tenth day as satisfying their training requirements.

The evidence we received

76. The majority of our witnesses were against a length of stay of less than ten days and some advocated twelve or fourteen days. They considered that early discharge resulted in a division of responsibility for medical care and a lack of continuity of nursing care during the puerperium. Early discharge from hospital was detrimental to the establishment of breast feeding and encouraged the tendency for mothers to take up household tasks for which they were still unfit. So far as social cases were concerned homes unsuitable for delivery were not likely to be suitable for nursing during the puerperium. Some witnesses thought that patients were discharged at the convenience of the hospital with too little regard to the patients' physical condition. The British Medical Association stated that each case should be reviewed by the hospital doctor in the light of individual circumstances in consultation with the Medical Officer of Health and the family doctor so as to ensure that early discharge would not take place where home conditions were known to be unsuitable. One of our witnesses, although opposed to a shortened length of stay, thought that most mothers were restless in hospital once they were able to get out of bed and were unhappy if they remained for the normal lying-in period separated from their husbands and children.

77. Another aspect of the matter stressed by some witnesses was the detrimental effect that early discharge had on both hospital and domiciliary midwifery staff. They said that the consequent increase in the number of confinements dealt with meant that the hospital staff were over-worked and were unable to devote enough time to the mother or to the training of pupil midwives. Domiciliary midwives who had to care for patients after their early discharge considered that they were being used as maternity nurses and thus deprived of the full satisfaction of their work.

78. A few witnesses were in favour of a shortened length of stay. One Regional Hospital Board wished to increase the number of hospital confinements by sending home within twenty-four hours of delivery those multi-gravidae with no medical or social reasons for retention. They doubted the need for a trained midwife to look after patients after early discharge from hospital. They recommended that there should be a review of the nursing techniques, now laid down for midwives, both in and out of hospital.

79. We were particularly interested in a survey which the Liverpool Regional Hospital Board had proposed to make, in co-operation with the local health authority and the University of Liverpool, into the effects of early discharge. We understand that in fact this survey was not carried out but we would welcome a carefully controlled investigation of that kind which, if it demonstrated that a shorter stay in hospital could be achieved without detriment to the mother or the child, might justify some modification of our recommendation.

80. We also had some evidence about the average length of stay in hospital of mothers in a number of foreign countries. In Sweden where in 1954 some 96 per cent of all confinements took place in hospital the average length of stay was seven to eight days. In towns in the U.S.A., where nearly all deliveries were in hospital, the average length of stay for all cases was normally only a few days. We understood that in New York in 1951 the average length of stay after delivery was about seven days for mothers who had had live births and that there were little or no nursing facilities in the home for the mother discharged from hospital. Breast feeding was not common in America and its establishment was not a factor there in deciding how long a mother stayed in hospital. The cost of hospital confinements to a family in the U.S.A. was very considerable and seemed to be an important reason for leaving hospital early.

Our views

81. We have considered the evidence we have received concerning length of stay in hospital and we think that experience in this country justifies adherence to a period of ten days as the normal (not average), stay in hospital after delivery. We think this is necessary for the establishment of breast feeding, for the treatment of complications liable to occur during this time and to avoid a premature change of regimen or a too early resumption of household duties. We have noted the practice of early return to the home in some other countries, particularly in the United States, but we have had no means of establishing what effects this may have had upon the subsequent health of the mother and child.

82. We recommend that the provision of hospital maternity lying-in beds referred to in paragraph 70 above should be planned on the basis of a normal length of stay in hospital, after delivery, of 10 days.

83. It will be necessary to provide additional maternity beds to achieve the 70 per cent average hospital confinement rate. An assessment of the actual number required is complicated by the fact that the existing provision of beds varies very much in different parts of the country. The average period during the year in which a maternity bed is unoccupied is proportionately higher than that for the other hospital beds, and this period varies considerably in different hospitals. There are many factors which can cause this

including staff shortages, the number of emergency admissions, the closure of wards because of infection and the type of the maternity unit. Investigation has shown that there is a wide divergence from about 60 per cent to 95 per cent in the bed occupancy rates throughout the country so that no average rate can usefully be quoted. Any assessment of the provision of maternity beds is complicated by the wide variation in the birth rate at different months of the year. (See Table III below.) Furthermore, while we have recommended a minimum stay in hospital of 10 days after delivery, some patients will require a longer period and we are therefore unable to assess accurately the probable average length of stay. We consider that hospitals would be unwise to book patients for admission to more than about 80 per cent of their lying-in beds if without overcrowding they are to leave sufficient beds for emergencies and to allow for the variability in the number of admissions the dates of which cannot accurately be forecast. However, it seems clear that in some areas at least assuming a normal 10 day stay in hospital additional beds will be required and it must be left to the hospital authorities to decide what provision will require to be made in the light of their own local needs. We discuss the provision of ante-natal beds in paragraphs 71, 230 and 231.

TABLE III

Table showing the number of confinements in England and Wales during 1956 in the month of occurrence

January	...	...	...	59,214	July	...	...	...	60,103
February	...	...	...	56,957	August	...	...	...	58,074
March	...	...	...	64,736	September	...	...	...	58,022
April	...	...	...	61,884	October	...	...	...	56,491
May	...	...	...	62,581	November	...	...	...	53,500
June	...	...	...	58,956	December	...	...	...	57,403

84. We are under no illusions about the financial and staffing difficulties which the adoption of this recommendation will involve and in areas where this level cannot be achieved for the time being we can see no overriding objection to earlier discharge in carefully selected cases. It should be the duty of the hospital authorities, with the patient's consent, to ensure that her family doctor will accept the responsibility for her further care before discharging her and to ascertain in every case whether the home is suitable. We do not think that it is sufficient to consult the woman herself and it must be remembered that a woman admitted to hospital on medical grounds may also have adverse home conditions.

85. We appreciate that a normal length of stay of ten days coupled with an increase in the proportion of hospital confinements may have repercussions on several aspects of the maternity service. The importance of ensuring that post-natal care continues after a woman is discharged from hospital has already been stressed. We wish to recommend that the local health authority and the patient's family doctor, with her consent, should always be informed by the hospital authority of the date on which she is to be discharged, irrespective of the time she has spent in hospital.

86. It has been suggested to us that, if the normal length of stay after delivery should become ten days, the Central Midwives Board might consider amending their Rules to reduce the minimum of the lying-in period defined therein, from fourteen days to ten days. Although we are satisfied that a ten day stay in hospital is normally long enough, and that special nursing is not normally necessary after this time, we wish also to stress the need for the mother to have advice and guidance during the weeks that follow. There should not be any gap between the end of the period of maternity nursing and the beginning of the period of post-natal supervision. Exactly when, after ten days, the midwife should hand over her charges to the care of the health visitor will vary under different conditions, and indeed in the case of home confinement it will generally be more convenient to make the change-over at some later time. The Central Midwives Board recognises the importance of the need for elasticity in defining the length of time that the midwife should retain her responsibilities to the mother and child. At present the Board defines the "lying-in period" as not less than fourteen, and not more than twenty-eight days after confinement, and this definition forms the time basis for certain statutory duties of local authorities under the National Health Service Act, 1946. We appreciate that the Central Midwives Board is concerned with the length of stay in hospital primarily from the point of view of training pupil midwives, but it is also concerned with the "lying-in period" in relation to the duties of practising midwives. There can be no objection to retaining the upper limit of the definition of the "lying-in period" at twenty-eight days; indeed if, in the future, there should be a re-distribution of duties between the health visitor and the midwife, this high upper limit might be essential. On the other hand we suggest that the Central Midwives Board might consider the wisdom of altering the lower limit of its definition from fourteen to ten days. If, after consideration of all the implications, the Board decided that there was no objection to the change, it would certainly bring the statutory duties of local authorities into line with present day practice. The care of a patient who was discharged from hospital on the tenth day could then, if appropriate, pass immediately to a health visitor, instead of first to a midwife for a few days and then to a health visitor.

THE EFFECTS OF A HIGH HOSPITAL CONFINEMENT RATE ON DOMICILIARY MIDWIFERY SERVICES

87. The point was made by some of our witnesses that if the proportion of hospital confinements continued to increase throughout the whole country a stage might be reached where local authorities would be unable to run an economical and efficient domiciliary midwifery service for those patients who preferred to be confined at home. Information we received from a number of areas in which the proportion of hospital confinements was already high, indicated that a very high hospital confinement rate might increase the per capita cost of the domiciliary midwifery service because of the maintenance of a midwifery staff and an organisation which was not fully employed but could not be reduced. Staffing problems in relation to holidays and training of pupils were rendered very difficult because of the small number of staff employed.

COMPARABLE COSTS OF HOME AND HOSPITAL CONFINEMENTS

88. We were anxious to compare the relative costs, both to public funds and to the mother, of hospital and home confinements. We include as Appendix V some of the information we obtained. As we there indicate, we found that it was extremely difficult to obtain strictly comparable costs. It appeared, however, that domiciliary confinements did in fact cost less to public funds than did hospital confinements, although the difference in cost was less than was often thought. This difference was further narrowed where the length of stay in hospital was short. The general practitioner maternity unit was not much cheaper than the maternity hospital when account was taken of the maternity medical service fees payable to the general practitioner.

89. It seemed to us probable that the cost to the mother of a domiciliary confinement was greater although it was impossible to say how much greater. Paragraph 24 of the "Report of the National Insurance Advisory Committee in accordance with Section 41 of the National Insurance Act, 1946, on the Maternity Benefit Provisions" published in 1952 as Command 8446 stated that . . . "we are concerned that so far as practicable, there should be no financial pressure on a woman either to have her confinement at home or in hospital. Her decision should be taken on other than financial grounds." The home confinement grant, at present £5, was we thought unlikely to cover the cost of food (which in hospital was provided free), minor equipment and the additional home help that the mother confined at home was likely to require. We consider that with the changing value of money the amount of the home confinement grant should periodically be reviewed.

CONCLUSIONS AND RECOMMENDATIONS

- The hospital maternity service should be expanded and a good domiciliary maternity service should continue to be maintained. (Paragraph 60.)
- A more uniformly high standard of ante-natal care is essential. (Paragraph 60.)
- A more careful selection of patients should be made for domiciliary confinements and for admission to hospital. (Paragraph 60.)
- The local health authority is the appropriate authority to determine whether social reasons make a home confinement undesirable and they should always be consulted by hospital authorities before a decision is made to book a patient solely on social grounds. (Paragraph 69.)
- Sufficient hospital maternity beds to provide for a national average of 70 per cent of all confinements to take place in hospitals should be adequate to meet the needs of all women in whose case the balance of advantage appears to favour confinement in hospital. (Paragraph 70.)
- Hospital authorities should, in addition to beds needed for confinement and lying-in, provide as a priority, ante-natal beds for 20 per cent to 25 per cent of all confinements in their areas. These beds should be reserved solely for ante-natal patients. (Paragraph 71.)
- Experience in this country justifies adherence to a period of ten days as the normal (not average) length of stay in hospital after delivery. (Paragraph 81.)

● In some areas additional hospital maternity beds will be required and it must be left to the hospital authorities to decide what provision will require to be made in the light of their own local needs. (Paragraph 83.)

● The local health authority and the patient's family doctor should, with the patient's consent, be informed by the hospital authority of the date on which she is to be discharged, irrespective of the time she has spent in hospital. (Paragraph 85.)

● The Central Midwives Board might consider amending their Rules to reduce the minimum of the lying-in period defined therein from fourteen to ten days. (Paragraph 86.)

● The amount of the home confinement grant should periodically be reviewed. (Paragraph 89.)

CHAPTER 6

THE WORK OF MIDWIVES

Present arrangements

90. Nothing could better illustrate the importance of the midwife in the maternity service than the fact that during 1956 about 80 per cent of all deliveries were conducted by midwives. This does not necessarily mean that the doctor was not present during the confinement. We ourselves were constantly reminded of the important role that the midwife plays in providing maternity care whether under the aegis of the local health authority, the general practitioner obstetrician or the maternity hospital.

91. The Central Midwives Board were formed under the Midwives Act, 1902, to keep, *inter alia*, the Roll of Certified Midwives: their present constitution was laid down under the Midwives (Constitution of Central Midwives Board) Order, 1952. The Board have exercised their statutory powers under the Act to make Rules which are published as a Statutory Instrument (The Midwives Rules, Approval Instrument, 1955 No. 120). Among other matters these Rules lay down conditions governing the training and practice of midwives.

92. Courses of training take place only at institutions approved by the Board and comprise two parts, each followed by an examination. For registered nurses Part I training lasts 6 months; for others 18 months. Part II training lasts 6 months of which at least 3 months must be spent in domiciliary practice. The Board normally approves an institution either for Part I or for Part II training; only exceptionally is an institution approved for both. Intending pupils, who must not be under 20 or, except where the Board allows, over 50 years of age, apply to an institution approved by the Board and give evidence either of their registration as nurses or of their general education. They can be removed from the Register of Pupils if an adverse report is made after 6 months.

93. The local health authorities (County Councils and County Borough Councils) are designated local supervising authorities for the purposes of the Midwives Act, 1951. Their duty is to supervise all midwives in their area.

whether working in a hospital, in domiciliary practice, or in nursing homes. To carry out these duties local supervising authorities may appoint medical and non-medical supervisors, whose qualifications are prescribed by regulations. The Rules of the Central Midwives Board go beyond the statutory requirements of the Act in requiring midwives to give notice to the local supervising authority if they intend to act as maternity nurses and for this purpose they define a maternity nurse as a midwife who in any maternity case is acting for the time being under the direction and personal supervision of a registered medical practitioner.

94. The Rules for the regulation and supervision of the practice of midwives provide for the following:

- (a) the form in which a midwife must notify the local supervising authority every year of her intention to practise (a) as a midwife or (b) as a maternity nurse only;
- (b) a maternity nurse must obtain instructions from the doctor in charge of the case;
- (c) a midwife must keep a register of all her cases in a prescribed form and make this available to the local supervising authority;
- (d) a midwife must keep a record of her observations and treatment of her patients. This should be in the prescribed form and should be available to the local supervising authority;
- (e) a midwife must not undertake treatment outside the normal province of a midwife except in emergency, nor use any drug or analgesic apparatus in the use of which she has not been trained or which is not approved by the Board; and she must keep records of any drugs used;
- (f) the circumstances in which and the procedure by which a midwife must call in a doctor in all cases of illness or abnormality of the patient or baby during pregnancy, labour or lying-in period, and must notify the local supervising authority;
- (g) a midwife must notify the local supervising authority (a) if she has been in contact with an infectious condition; (b) if artificial feeding is adopted; (c) of deaths and stillbirths;
- (h) every midwife who has given notice of intention to practise as a midwife and every midwife employed by a local supervising authority as a supervisor or assistant supervisor of midwives must every five years attend a refresher course approved by the Board.

95. In addition there are Notices concerning a midwife's "Code of Practice" which are not part of the Rules and are not included in a Statutory instrument, but midwives are warned that failure to maintain the standards of work indicated in the Notices may render them liable to a charge of negligence or misconduct. As regards ante-natal care the Notices say that a midwife must carry out such examinations of the patient as are necessary, or see that they are carried out. She must advise the patient to present herself for medical examination early in pregnancy, at about the 36th week and otherwise as necessary.

96. The Rules of the Central Midwives Board define the lying-in period as "a period being not less than 14 days or more than 28 days after the end of labour during which the continued attendance of the midwife on the mother and child is requisite". These Rules do not govern the length of stay in hospital but the Central Midwives Board will approve training schools only if they provide pupil midwives with satisfactory experience in the nursing of the mother during the lying-in period. The Board do not now insist

on the requisite experience of nursing in the lying-in period extending over the full 14 days but accept the common practice of discharge on the 10th day as satisfying their training requirements.

THE NUMBER OF MIDWIVES IN PRACTICE

The evidence we received

97. The whole question regarding the shortage and recruitment of nurses and midwives is being considered by the National Consultative Council on Recruitment of Nurses and Midwives and we would not wish to trespass on their field. It seems clear, however, from the evidence we received from a number of witnesses, including the Central Midwives Board and the Queen's Institute of District Nurses, that there is a shortage of midwives both in the hospital and domiciliary fields but especially in hospital midwifery. This is due not to a lack of trained midwives but to the fact that many nurses who have taken midwifery training do not practise midwifery but use their qualification for higher posts in other branches of nursing. In many cases these nurses had never intended to practise midwifery.

98. The Central Midwives Board said that the majority of midwives being enrolled were general trained nurses and were able easily to change to other work. Nearly 3,500 midwives were trained every year but by the end of three years only 800 of them were still in practice, although some might practise again at a later stage. The Board had records of 70,000 midwives of whom only 17,000 had notified their intention to practise. It was pointed out that while only about 5 per cent of those who started training as midwives were not State Registered Nurses, 23 per cent of those already in practice were not State Registered Nurses. On the average midwives who were not State Registered Nurses stayed in midwifery for about twelve years and were mostly older women who had come from other occupations or who were married. It was said that although there were very few promotion prospects in hospital for these midwives they were among the best recruits to the profession. We were informed that the number of pupil midwives entering training schools for Part I training was 4,684 in 1955-56 and 4,518 in 1956-57, a decrease of 166. Pupils taking Part II training showed a decrease of 335, from 2,953 in 1955-56 to 2,618 in 1956-57. The wastage in training, confined almost entirely to Part I pupils, was about 5 per cent of registrations. It was suggested to us that if the domiciliary confinement rate continued to decrease the opportunities for training pupil midwives in domiciliary work may not be adequate.

Our views

99. There is a shortage of practising midwives, particularly in the hospital service. Apart from the consideration which is being given to this matter by the National Consultative Council on Recruitment of Nurses and Midwives, we understand that the General Nursing Council and the Central Midwives Board are discussing the practicability of incorporating a short course on midwifery, excluding the conduct of deliveries, in the basic nursing syllabus. Furthermore if the recommendation of the Working Party on Health Visitors is implemented, it may be that in future health visitor training schools will not require students to have passed Part I of the midwives' examination particularly if the general nursing syllabus contains enough midwifery to be acceptable to the health visitor training schools. It is probable that this will not affect the actual number of practising midwives but it will result in a

saving of valuable time at present spent in midwifery training and of experience which remains unused.

100. If the number of domiciliary confinements falls too low it may be necessary for the Central Midwives Board to review the present arrangements for the domiciliary training of midwives.

INTERCHANGE OF DOMICILIARY AND HOSPITAL MIDWIVES

The evidence we received

101. Whatever the future effects of revised training arrangements may be we have at present to contend with what appears to be a chronic shortage of midwives, especially in hospitals. Some witnesses thought that in order to make full use of those midwives who were practising, hospital and domiciliary midwives should be in some way interchangeable so that they might work in either hospital or home according to the needs of the area. It was suggested that this interchangeability would become all the more necessary in view of the increasing proportion of hospital confinements.

102. We received evidence which indicated that domiciliary work attracted many midwives who would not in fact practise at all if they had to work in a hospital. Appeals from short staffed hospitals to domiciliary midwives were said to have met with a poor response. We were told that domiciliary midwives frequently were married women with homes of their own and that although many married nurses worked in hospitals fewer married midwives did so. Many of the domiciliary midwives felt that they had a closer relationship with their patients and a greater responsibility for their care than had hospital midwives who saw their patients only during their short stay in hospital, and who had medical assistance near at hand.

Our views

103. We consider that a greater obstacle than those mentioned above to any interchange of hospital and domiciliary midwives is the fact that a large proportion of the domiciliary midwives combine their midwifery duties with those of district nurses, health visitors or with other nursing duties for the local health authority, a matter we discuss in paragraphs 119 to 121 of our Report. Any widespread attempt to use these midwives for hospital work would disrupt the other domiciliary services of the local health authorities and might, because of the reluctance of many midwives to work in hospital, result in fewer midwives being prepared to practise at all. On the other hand as we have shown the present dichotomy is largely a matter of tradition and evolution but should this interchange be made a normal condition of employment on recruitment to a joint service with a common employer no doubt it would become acceptable in due course.

THE STATUS OF THE MIDWIFE

The evidence we received

104. Several of our witnesses stressed the importance of preserving the status of the midwife in the maternity medical services and the hospital maternity services now developing under the National Health Service. These witnesses expressed the same views as those in the Report of the Working Party on Midwives (1949) which emphasised that the responsibilities of doctor and midwife were complementary and that the maternity services

would be successful only if both parties recognised their partnership. The Report said that the doctor should accept the midwife as his fellow practitioner and not attempt either to relegate her to the status of his assistant or to displace her unnecessarily from her position of authority in the eyes of the patient. The midwife for her part should not be over possessive about her patients and must be ready and willing to summon the doctor whenever an abnormality required his skill. The Report considered that the midwife should be the practitioner of normal midwifery, the expert in all its aspects. The doctor was her partner in the detection and treatment of abnormalities. The Working Party also emphasised that the midwife was no mere "delivery woman" concerned primarily with the skilful delivery of a live child. She had assets of time, skill and attitude of mind which were of immense value to the patient. Her work started early in pregnancy and in the view of the Working Party should continue for a month after delivery.

105. However, our witnesses indicated that, in the years since the Report of the Working Party on Midwives was published, the midwives' fears that the provision of maternity medical services by general practitioners would tend to be a threat to their own professional status have been allayed and that midwives and doctors providing domiciliary midwifery were in general co-operating well. In only a few instances did our witnesses refer to cases of midwives discouraging mothers from booking doctors or of doctors discouraging mothers from attending midwives for ante-natal care.

Our views

106. We have stated elsewhere in our Report, when discussing the local authority midwifery service and the maternity medical service, that in our view it is important that every woman who proposes to have her baby at home should book both a doctor and a midwife. At the earliest reasonable time they should arrange that all necessary maternity care will be given and that it is shared between them.

107. We find ourselves in agreement with the opinion of the Working Party on Midwives that the midwife's three assets of time, skill and attitude of mind are of immense value to her patient. We are convinced that it is desirable that a midwife should be given every opportunity to participate in the maternity care of her patients to the fullest extent to which her skill and experience entitle her. Nothing should be done to lessen the importance of the midwife.

MATERNITY NURSES

108. We discuss in Chapter 7 the question of co-operation between the midwife and the general practitioner obstetrician in ensuring that all proper maternity care is provided and in deciding which of them should conduct the delivery. We have received evidence that the present practice under which a midwife at a delivery acting under a doctor's supervision is referred to as a maternity nurse is resented by midwives. We understand that the Central Midwives Board are considering this matter. We would recommend that the term "maternity nurse" in as far as it is applied to certified midwives should be reserved solely for a midwife who had notified her intention to practise as a maternity nurse only. This would we understand safeguard the part-time maternity nurse who does not undertake deliveries and is not required to attend refresher courses.

109. The Royal College of Midwives suggested that the nursing administration of a maternity hospital, whether or not it was part of a general hospital, should be under the control of an experienced midwife. They considered that the results were more satisfactory than where the head of the midwifery staff had always to refer to the matron of the general hospital who might not be a trained midwife. It was said that at present there was some dissatisfaction among midwives especially in cases where the matron of a general hospital did not delegate to the superintendent midwife duties such as the appointment of pupil midwives and other staff.

110. We have had little evidence from other witnesses on this administrative aspect of hospital organisation although we appreciate that the Royal College of Midwives represents those most intimately concerned. We are aware that the subject has been discussed in the past by the Central Health Services Council and that in 1954 their views were commended to hospital authorities by the Minister of Health. (See footnote.) We understand, however, that this advice has not been adopted by all hospital authorities. We suggest that the Minister should ensure that this advice is implemented. This should provide midwives with better career prospects.

CONCLUSIONS AND RECOMMENDATIONS

- Any widespread attempt at present to compel domiciliary midwives to work in hospitals might disrupt the domiciliary nursing services. We believe that this interchange might become acceptable to midwives if it were made a normal condition of service on recruitment to a joint service. (Paragraph 103.)

- A midwife should be given every opportunity to participate in the maternity care of her patients to the fullest extent to which her skill and experience entitle her. (Paragraph 107.)

- The term "maternity nurse" in as far as it is applied to a certified midwife should be reserved for a midwife who has notified her intention to practise as a maternity nurse only. (Paragraph 108.)

- The views of the Central Health Services Council regarding the status of the superintendent midwife, commended by the Minister of Health to hospital authorities in 1954, should be implemented. (Paragraph 110.)

Footnote: The following paragraphs were included in H.M. (54) 4 sent to hospital authorities by the Ministry of Health on 18th January, 1954:

HEAD MIDWIVES

8. The Minister has sought the views of the Central Health Services Council about the status which should be accorded to head midwives in hospitals. Their views, which the Minister commends to the attention of hospital authorities, are set out in the following paragraphs.

9. In any maternity department (within a general hospital) which is a training school* for pupil midwives, the superintendent midwife should be responsible for the administration of her department directly to the matron of the hospital and not to one of her subordinates. All midwifery staff and pupils appointed to the maternity department should be selected by the matron only after consultation and in agreement with the superintendent midwife.

10. Where the Hospital Group contains an ad hoc maternity hospital or a maternity department of sufficient size to justify the employment of a superintendent midwife, the matron of the ad hoc maternity hospital and/or the superintendent midwife should be members of the Group Nursing and Midwifery Advisory Committees. They should also receive copies of all circulars and instructions having a bearing on the maternity work of the Group.

* The same principle would, of course, apply to any maternity unit which, though not a training school for pupil midwives, is large enough to justify the employment of a superintendent midwife.

CHAPTER 7

MATERNITY SERVICES PROVIDED BY LOCAL HEALTH AUTHORITIES

111. The domiciliary maternity services are provided by local health authorities, i.e., County Councils and County Borough Councils, as a duty under Part III of the National Health Service Act, 1946. These services include the care of mothers and young children and the provision of ante-natal and post-natal clinics; a priority dental service for expectant and nursing mothers; a domiciliary midwifery service for women who are being confined at home; a health visitor service to give advice to expectant and nursing mothers and certain services such as the provision of domestic help and ambulances which, although not confined to maternity cases, form an important adjunct to the maternity services.

112. The Guillebaud Committee concluded that the provision of the domiciliary health services was essentially a local authority function and that it would be a mistake to transfer that function to any other authority. In their view it was desirable that all types of public health work should remain with the local authorities and that there should be the closest possible integration of the domiciliary health services provided under the National Health Service Act and the welfare services provided under the National Assistance Act. They were satisfied that the County Councils and the County Borough Councils were the right authorities—bearing in mind the areas they served and the resources they commanded—to plan and administer the local health and welfare services in co-operation with the hospital authorities and the Executive Councils.

113. These conclusions were reached by the Guillebaud Committee before the Government's proposals for the re-organisation of local government, now embodied in the Local Government Act, 1958, were known. Under the provisions of that Act boroughs and urban districts (not rural districts) with a population of 60,000 or more are entitled to have the administration of the local health and welfare services delegated to them by the County Councils if they ask for it: urban authorities with less than 60,000 population and rural district councils who want delegation will have to satisfy the appropriate Minister that there are special circumstances which would justify it. Any delegation scheme must include *all* the personal health services, including the domiciliary midwifery service, in order to ensure a comprehensive and co-ordinated service.

114. Appendix VI shows a list of the 59 boroughs and urban districts in England and Wales with a population of 60,000 or more as at 30th June, 1957: 39 of these districts are in the Metropolitan area to which the Act does not apply. Only 20 districts are entitled under the Act as of right to have the health and welfare services delegated to them.

115. We cannot of course foresee what will be the policy of the Minister when authorities with less than 60,000 population apply for delegated powers but think that it is probable that it may be more or less comparable with that followed by the Minister of Education under the Education Act, 1944. In the event the Minister of Education gave delegated powers to 7 "excepted districts" below the critical size of 60,000 population laid down in the Act.

There was no critical size for a divisional executive area but in fact no less than 57 divisional executives were set up with less than 60,000 population. The pace having been set by one local authority service local pressure seems likely to ensure that it is maintained by another.

116. We find it difficult to estimate what effect the new arrangements envisaged in the Act will have on the administration of the domiciliary maternity and midwifery services at present carried out by the County Councils. *Prima facie* it would seem that because a larger number of bodies will be involved in carrying out the services it would be more difficult to secure the necessary co-operation and co-ordination. This will certainly be the case where the catchment area of a maternity hospital covers a medium sized town to which the domiciliary services have been delegated and also its surrounding rural hinterland where those services are still administered without delegation by the County Council. The same conditions exist today where a hospital in a County Borough serves also part of the surrounding County, but it would seem likely that under the delegation arrangements these difficulties will be multiplied. On the other hand where the boundaries of one of these new authorities are co-terminous with the catchment area of a maternity unit co-operation may well be easier than when the authority was merely part of a County. We think it will be particularly important that the authorities with delegated powers should maintain close contact with the Hospital Management Committees and Executive Councils in their areas. We hope that the Minister will bear these considerations in mind when deciding whether or not to approve delegation to the smaller authorities.

117. It seems to us probable that some of the authorities with delegated powers, even those with populations of 60,000 or more, will, because of the small number of domiciliary confinements, find it difficult and uneconomical to run an efficient domiciliary midwifery service. We suggest that local authorities where this occurs might find it convenient to make arrangements in accordance with section 23 of the National Health Service Act, 1946, for the domiciliary midwifery service to be provided by the local Hospital Management Committee. This might well provide an experiment, which we would welcome, in the co-ordination of the institutional and domiciliary midwifery services which could result in a more even distribution of midwives.

DOMICILIARY MIDWIFERY SERVICE

Present arrangements

118. It is the duty of local health authorities to secure that an adequate number of certified midwives is available in the area to attend women in their homes during childbirth and during the lying-in period. Local health authorities may themselves employ the midwives or they may enter into arrangements with hospital authorities or voluntary organisations to provide this service as their agents. In any one local health authority area a combination of these methods may be in force.

119. In some areas domiciliary midwives act also as home nurses, health visitors or school nurses or combine any of these duties. This arrangement has been found to be suitable and sometimes essential in rural areas where the full case-load of a whole-time midwife would be drawn from an area too large to be conveniently covered by one person. There were in 1957 some

7,487 midwives both whole-time and part-time engaged in domiciliary practice. Of these about 6,633 were employed directly by local authorities, 773 by voluntary organisations and 81 by hospitals acting under arrangements with local authorities.

120. Of the 6,633 midwives employed by local authorities and their agents 4,060 had combined duties as follows:

Midwife and home nurse	...	...	...	...	2,880
Midwife and health visitor	...	...	...	...	3
Midwife, home nurse and health visitor	...	...	...	...	236
Midwife, home nurse and school nurse	...	...	...	...	44
Midwife, health visitor, school nurse and home nurse	...	...	...	...	876
Midwife, home nurse, health visitor, school nurse and tuberculosis visitor	...	...	...	...	21

121. It is this practice, which appears inevitable in many less populated districts, of employing multi-purpose nurses on domiciliary duties which creates one of the major practical difficulties in any attempt to sever the domiciliary maternity service from the other nursing services of local health authorities and to transfer the maternity service either to the hospital authorities or to some other body designed to unify the different aspects of maternity care.

122. With the introduction of the maternity medical services under the National Health Service Act, 1946, the rôle of the domiciliary midwife has undergone some change. Formerly it was usual for a midwife who was booked for a home confinement to carry out, with the local authority doctor, all ante-natal care and to attend unaided at deliveries, calling on a general practitioner only in an emergency. Midwives are now encouraged to ensure that a woman also books a general practitioner obstetrician or her own family doctor. The woman receives her ante-natal and post-natal care from both the doctor and the midwife.

The evidence we received

123. The Central Midwives Board in evidence to us suggested that the midwife was becoming much more of a welfare agent, and was for instance concerned not only with her own patients but also with patients discharged early from hospital. They considered that a system was needed whereby a midwife should with the consent of the patient be made aware of any woman in her own district who became pregnant, whether she was to be confined at home or in hospital. The midwife should then ensure that the woman received the necessary ante-natal care, and in the case of the hospital booked patient, that she had made preparations for her care after being discharged from hospital. They thought the midwife should ensure that there was no confusion between herself, the hospital, the local authority clinic and the general practitioner, about who was really supposed to be looking after the patient. One witness thought that if this general supervision were recognised as part of the duty of a domiciliary midwife it would give her a fuller and more satisfying job and would overcome any tendency towards midwives being under-employed.

124. All our witnesses were agreed that for a domiciliary confinement a woman should book both a doctor and a midwife for her ante-natal care and

confinement. There was some criticism that the midwife was not always informed of the findings of the doctor's examination, and that very little co-operation or co-ordination had been developed between them.

125. We received evidence which recommended that the doctor and the midwife should consult at the 36th week of pregnancy and decide which of them was to undertake the delivery. In the view of several of our witnesses the distinction between midwifery and maternity nursing had no meaning in these circumstances. Although final responsibility rested on the doctor, the midwife continued to conduct the delivery in a large number of cases. Our witnesses were agreed that the midwife, where possible together with the doctor, should see the patient, either at his surgery, the local authority clinic or at the patient's home, and that they should continue to do so throughout the antenatal period. The midwife should in any event make intermediate visits to the patient as necessary.

126. Although one of our witnesses said that the holding of special sessions with the midwife in doctors' surgeries had proved a failure the evidence generally indicated that it worked very well in some areas, especially where a considerable amount of maternity work in a well defined district was concentrated in the hands of an enthusiastic general practitioner obstetrician. It was thought by some of our witnesses that the midwife should attend clinics held in a doctor's surgery where he had sufficient maternity work for special sessions. Others suggested that a midwife should in some cases serve a group practice which undertook a considerable amount of maternity work.

127. We were particularly interested in the evidence of a doctor who described the co-operation between himself and midwives at the clinics he held in his surgery. Every patient was examined by himself and the midwife at each attendance. The clinic, at which an average of 18 patients attended, lasted for two hours on one afternoon a week, and as each patient was seen between eight and ten times a successful rapport was established. The doctor was informed of the onset of labour at the same time as the midwife and attended as soon as possible. A full examination at the beginning of labour enabled a fairly accurate assessment to be made and instilled confidence in all concerned. The doctor visited the patient as often as he thought necessary during labour to encourage, advise or instruct. At all times he took the midwife into full consultation and the labour was conducted on their agreed plan. Although the doctor liked to be present the actual delivery was usually conducted by the midwife, unless any difficulty was expected. He visited mother and child frequently during the puerperium, maintaining contact with the midwife. Ninety per cent of mothers attended his post-natal clinic held six weeks after delivery.

128. We had some evidence of the variety of present practice in relation to the after-care of mothers discharged after a hospital confinement. It seemed usual, although not invariable, that after an early discharge, the local health authority and sometimes the general practitioner were notified by the hospital authorities so that the necessary after-care could be arranged. In the case of discharge after ten days, however, such notifications were less usual. We were told that domiciliary midwives disliked undertaking maternity care of a large number of patients discharged early from hospital for whose delivery they had had no responsibility.

129. We consider that every woman accepted for a home confinement should book both a midwife and a general practitioner obstetrician for her maternity care. While both doctor and midwife should regard it as their joint obligation to ensure that adequate maternity care, including all necessary local authority services, is provided, we think that co-ordination is most likely to be achieved if one person is held responsible for it. We consider that this responsibility should be placed on the doctor who has booked the patient for maternity services. Ante-natal examinations should where possible be carried out with both the doctor and the midwife present, or in cases where only one is present, written information of the results of the examination should be sent to the other.

130. We see no inherent difficulty in the present arrangement whereby the domiciliary midwifery service is undertaken by midwives responsible to the local health authority and the maternity medical service is undertaken by general practitioner obstetricians responsible to the Executive Council. The problem of co-operation and co-ordination of the work to be done inevitably arises when more than one person is involved whether or not there is a single employer. We have heard enough evidence to convince us that, given the willingness, co-operation can be developed to an extent which could hardly be bettered in a unified service.

131. It is important that the respective responsibilities of all those involved in maternity care should be understood and that proper records should be maintained to ensure that co-ordination is achieved. We deal with this more fully in Chapter 11. It is in the interest of the patient, the doctor and the midwife that, as far as possible, a programme of the maternity care that is likely to be required during the ante-natal period, the confinement and the puerperium, should be arranged as early as possible after confirmation of pregnancy and decisions should be made as to which part of it is to be provided by the midwife and which by the doctor.

132. We appreciate that most domiciliary deliveries are normal but complications can and do arise. Although we do not wish to lessen the midwife's responsibilities, we consider that where possible the doctor who has booked the patient should be present at the delivery. This does not mean that he should himself invariably undertake it. We consider that to define a midwife as a maternity nurse merely because a doctor is present at a delivery should be discontinued. (See paragraph 108.)

133. It is important that, with the patient's consent, the date she will be leaving hospital should be notified before her discharge by the hospital authority to the local health authority and to the general practitioner. This should be done for all patients, but particularly in the case of those discharged early, to ensure that all necessary care will be arranged.

THE PATIENT'S CHOICE OF MIDWIFE

134. It was suggested to us that a mother should have a free choice of midwife because it was important that she should have complete confidence in the midwife who undertook her care. We are in sympathy with this suggestion but we realise that its implementation might be difficult.

A domiciliary midwife usually attends all the patients in an area, and in rural areas particularly it would probably prove very difficult to arrange a choice of midwife unless the midwives worked in teams. We realise that at best the choice could be only a very limited one.

MIDWIVES IN AMBULANCES

135. Some of our witnesses suggested that the number of births taking place in ambulances indicated the need for a midwife to accompany each ambulance called out to take a maternity case to hospital. As an alternative, it was thought that volunteers might be found who would be prepared to accompany women to hospital. At present it was generally left to the ambulance driver or attendant to assist where necessary and it was usually expected that a relation or neighbour would accompany the expectant mother from home to hospital.

136. In our view this is not a serious problem. Shortage of midwives would prevent a hospital from providing a midwife escort for each woman booked for hospital delivery. A woman being attended at home and transferred to hospital in an emergency would probably be accompanied by the domiciliary midwife attending her. We feel that any solution is best left to local initiative.

THE LOCAL AUTHORITY ANTE-NATAL CLINICS

Present arrangements

137. The ante-natal and post-natal clinics provided by the local health authorities existed before the introduction of the National Health Service. At that time they were the core of the local authority maternity services and were designed to provide medical and general advice and attention for expectant and nursing mothers. With the coming of the National Health Service and the development of the maternity services in the hospitals and the maternity medical services under general practitioners, it was to be expected that the purely ante-natal and post-natal functions of the clinics would diminish. In fact the total number of attendances at local authority ante-natal clinics steadily declined from 1,750,000 in 1949 to 1,388,000 in 1955. In 1956, however, the number of attendances increased to 1,424,000 and in 1957 further increased to 1,450,000 because of an increase in the number of women attending midwives' sessions.

138. Most local authority ante-natal sessions are held in premises owned or rented for the purpose by the authority. They vary from the ad hoc clinic sharing a building with other local authority services to a church hall rented on certain days of each week. The clinics are in general staffed by local authority medical officers and a nursing staff of midwives and health visitors. The local authority doctor carries out ante-natal and post-natal examinations of women who have booked a midwife only for their confinement, of those women referred by the general practitioner, and sometimes of patients who have booked for a hospital confinement. The local authority doctor does not, however, attend deliveries. The local authority clinic is also used as a centre for the priority dental service for mothers and young children, for health

education including mothercraft and relaxation classes and for the distribution of welfare foods. It can provide an opportunity for group instruction. Furthermore, the clinics provide various facilities for general practitioners.

The evidence we received

139. It was the general view of our witnesses that there was no longer a place in the ante-natal clinic for the local authority doctor and that he would inevitably be superseded. It was said that he duplicated the work of the general practitioner obstetrician and that it was not sound practice for him to provide ante-natal care when he was not responsible for deliveries. A local authority representative, however, pointed out that the local authority doctor's wide experience made him an expert in ante-natal care and doubted whether the fact that he did not undertake deliveries affected his skill. There were suggestions by some witnesses who were reluctant to see the disappearance of the local health authority doctor, from ante-natal work that he should expand his experience by undertaking deliveries and should be linked more closely with the obstetric team by doing some hospital work. One of our witnesses went so far as to suggest that all general practitioners should cease to take maternity cases and that the maternity medical service should be undertaken by whole-time doctors employed by the local authority.

140. Most of our witnesses thought that local health authorities should continue to provide premises for ante-natal clinics. There was a general conviction that they were useful centres both for the provision of health education and as ante-natal clinics for use by midwives, general practitioner obstetricians and, in some instances, by hospital consultants. The London County Council pointed out that the clinic brought women into contact with the full range of local authority services. It was the best place for ante-natal and post-natal care because generally it was easily accessible, there was no waiting and the local authority service was organised for following up women who had failed to keep appointments for examination.

141. One witness suggested that local authorities should have a statutory duty to provide clinic facilities for general practitioner obstetricians. Other witnesses urged that the clinics should be used as centres for collecting blood for various tests and should be responsible for notifying general practitioner obstetricians of the results. Physiotherapy and instruction in the use of gas and air or other analgesic apparatus should also be provided.

142. In contrast to the evidence in paragraph 140 above other witnesses complained that women frequently had to wait for long periods at ante-natal clinics before they received attention. It was suggested that this could be remedied by a system of appointments. A further suggestion was that in rural areas, particularly where public transport was infrequent, special transport should be provided by the local health authority to take women to the clinics.

143. A number of witnesses wanted to see a closer linking of the clinics with the hospitals. One Regional Hospital Board for instance suggested that local authority clinics should be affiliated to certain hospitals while another Regional Hospital Board thought that the medical staff of the clinics should be associated with the hospitals. Several witnesses recommended that hospital consultants should staff local authority clinics, especially in remote areas ;

others thought that they should visit clinics to see hospital booked patients and some suggested that they should see general practitioner obstetricians' patients as well. One of our witnesses said that paediatricians should attend the clinics; another that the clinics should be retained for use by the hospitals on a tenancy basis. Several witnesses considered that local authority clinics should provide health education and mothercraft training for hospital booked patients. The clinic was, in the opinion of the London County Council, the best place for the interim care of hospital booked patients, particularly in London where it might save women the journey from the suburbs to a teaching hospital.

144. The British Medical Association took a different view from some of our other witnesses. They recommended that ante-natal clinics should continue to be administered by local health authorities, staffed wherever possible by general practitioners or, where these were not available, by medical officers employed by the local health authority. Only exceptionally should a consultant visit a clinic and then only on request from a general practitioner or a local authority doctor: if the latter the family doctor should be informed of the consultant's report.

145. We received many suggestions that general practitioner obstetricians should use the local authority clinics to provide their own and other general practitioner obstetricians' patients with ante-natal care, and also to undertake ante-natal care for hospital booked patients. Some general practitioner obstetricians already held their ante-natal sessions at local authority clinics but in one area at least the practice had been found to be extravagant in its use of local authority nursing staff.

146. We were told that the main difficulty was one of organisation. If the general practitioner obstetrician had a sufficient number of patients to justify the holding of a weekly session at the clinic that could easily be arranged. On the other hand if the patients lived in widely separated areas they would probably attend different clinics so that the number attending any one clinic would be too small to justify a doctor's attendance. It was thought that as an alternative general practitioner obstetricians could staff the local authority clinics on a rota basis and see the patients of other doctors as well as their own.

Our views

147. We have considered the position of the local authority doctor separately from that of the continued use of local health authority clinics. We should like to pay a very warm tribute to the local authority medical officers for the maternity work done by them over a long period. Prior to the National Health Service they undertook the maternity care of a large proportion of women for whom no other help was available. They are, however, being increasingly replaced by the doctors in maternity hospitals and by those undertaking domiciliary maternity services. If the average hospital confinement rate over the country as a whole reaches 70 per cent and if, as seems probable, the very great majority of those women who intend to have a domiciliary confinement book a doctor for their maternity care, the local authority doctor must it seems become superfluous. Moreover his work is limited to ante-natal and post-natal care and in our opinion it is not satisfactory that this should

continue to be given by doctors who do not undertake deliveries. We consider therefore that the general practitioner obstetrician should ultimately replace the local authority medical officer in providing maternity care in local authority ante-natal clinics. We foresee this taking place gradually over a period rather than by any sudden change.

148. Having concluded that the local authority doctor should ultimately be replaced by the general practitioner obstetrician we had to consider whether there was a future for the local authority ante-natal clinic, and if so, in what form it would continue. We are aware that the clinics will remain for other local authority duties and that they are indeed developing new uses such as providing for geriatric sessions. The premises will therefore still be available.

149. We are anxious that the present trend whereby ante-natal care is provided either by the general practitioner obstetrician or by the hospital should not lead to the elimination of the local authority clinic. Neither should it lead to the isolation of the care given by the general practitioner obstetrician from that given by the midwife or from the other services provided in the local authority clinics. The extent to which general practitioner obstetricians will find it convenient to hold sessions in the local authority clinics rather than in their own surgeries will vary from place to place. As we see it there need be no rigid pattern. Doctors will carry out their maternity work wherever it proves most convenient to themselves and to their patients. In rural areas there will probably be too few maternity cases to justify doctors holding sessions in local authority clinics: it will be more convenient for them to give ante-natal care in their own surgeries or in the patients' homes. We expect, however, that the restriction of the obstetric list (see paragraphs 192 to 197) will in most places provide general practitioner obstetricians with enough cases for ante-natal sessions either in the local authority clinics or in their own surgeries. Where the arrangement proves acceptable general practitioner obstetricians might give ante-natal care at local authority clinics to the patients of other general practitioner obstetricians or to patients booked for hospital delivery. We consider that so far as general practitioners are concerned the use of the local health authority ante-natal clinics should be reserved for doctors on the obstetric list. We see no objection, however, to their being used by hospital consultants for special cases. We are doubtful whether the clinics should ever be staffed by hospital consultants, a proposal which seems likely to be extravagant in the use of consultant manpower but there is everything to be said for consultant advice being available in clinics to general practitioner obstetricians who undertake domiciliary confinements.

150. We are satisfied that the local health authority should continue to provide premises and facilities for ante-natal clinics, without charge, to general practitioner obstetricians for the ante-natal care of their own patients or for those of other general practitioner obstetricians, and to hospital medical staff holding outlying hospital clinics. We believe that with the development of a closer association between general practitioner obstetricians and the hospitals the general practitioner obstetrician may well be doing the maternity care for many patients booked for hospital confinement.

151. We recommend that an appointment system should be instituted in all clinics to reduce waiting.

The evidence we received

152. There was general agreement among our witnesses on the importance to expectant mothers of health and mothercraft instruction. Several of our witnesses suggested that fathers too should be given an opportunity to participate in the instruction. The importance of certain aspects, such as mothercraft, physiology of pregnancy and labour, breast feeding and care of the breasts, relaxation classes, the use of analgesic apparatus and information about the maternity and child welfare services of the local health authority were stressed by various witnesses. It was thought that other aspects of a more general nature such as physical health and nutrition, which were not concerned exclusively with maternity care, could usefully be included because women during pregnancy were generally more receptive to health education.

153. Most of our witnesses considered that the local health authority because of its experience and its facilities was the most suitable body to undertake responsibility for carrying out health education, primarily in the form of group instruction. They considered it should be available both to women who were to have their babies at home and to those booked for hospital confinement. We had some evidence, however, that women receiving all their ante-natal care in hospital would not wish to attend a separate clinic for health and mothercraft instruction. Health education was given in some hospital ante-natal clinics and by some general practitioner obstetricians for their own patients. There was, however, criticism from various quarters that in general patients received very little, if any, instruction in mothercraft unless they attended the local authority clinics. There were suggestions that the person giving ante-natal care should be responsible for ensuring that the mother was offered instruction and that every hospital providing ante-natal care should arrange for it to be given. In general our evidence indicated that facilities for giving it were not always available, especially in hospitals and in general practitioner obstetricians' surgeries. It was found very frequently that women expecting their first children, who were most in need of mothercraft instruction, were going out to work and were unable to attend classes. We were told of one area in which out of fifty-six women attending child welfare clinics who were questioned about the health education they had received, thirteen had received none, twenty-one had casual advice from midwife or doctor, and twenty-two had attended a systematic course.

154. We received evidence from the Natural Childbirth Association and other women's organisations, to some of which we refer in Chapter 9 of our Report. The term "natural childbirth" as used by that Association referred to clinical methods which we felt were outside our terms of reference. This Association and other witnesses referred to the popularity of relaxation classes. These too are concerned with clinical methods on the value of which we would not wish to express an opinion.

Our views

155. We recommend that health education and mothercraft instruction should be available to all expectant mothers. Whoever is responsible for providing ante-natal care should also be responsible for ensuring that this instruction is given, either by himself or by arrangement with someone else,

and that the mother is encouraged to receive it. We think that this instruction need not be unduly elaborate. Circumstances will usually favour group instruction rather than individual instruction but this is a matter for local arrangement.

156. We recommend that it should be the duty of local health authorities to provide instructors in health education in their own clinics, and to offer their services in the surgeries of the general practitioner obstetricians or in hospital clinics as may be necessary. It will depend on local circumstances as to where this instruction is provided. Almost certainly the local health authority clinics will be the most suitable instruction centres for women booked for a domiciliary confinement as they frequently have more space and better facilities for the task.

157. With the growing hospital confinement rate, and the probability that most women having their first babies will be confined in hospital, the hospitals will have a special responsibility for seeing that health and mothercraft instruction are provided and they should ensure that adequate space and facilities are available in hospital premises for this teaching to be given.

158. We were impressed by the evidence of some teaching hospitals that a high proportion of the women who attended their ante-natal clinics had attended separate health education sessions organised by the hospitals. Not all women will find it possible to attend separate sessions for instruction but for those women booked for hospital confinement who can do so, it should be made available either at the hospital itself or at local authority clinics.

PRIORITY DENTAL SERVICE

159. Section 22 of the National Health Service Act, 1946, imposed a duty on local health authorities to make arrangements for the care, including dental care, of expectant and nursing mothers. In 1957, 45,237 expectant or nursing mothers were treated at local authority clinics. While the amount of conservation treatment has increased in recent years, extraction of teeth and the provision of dentures are still the most common forms of treatment.

160. Witnesses from the dental profession believed, although they found it difficult to prove, that there was a close relationship between the dental health and the general health of pregnant women. There was some criticism of the lack of dental care given to expectant mothers by maternity hospitals. It was considered that at present local health authorities could not, because of staff shortage, provide priority dental treatment for all expectant mothers except by co-operation with the general dental service.

161. It was suggested that one difficulty in achieving this co-operation was that whilst under the priority dental service local authorities were able to give partial treatment (they were for instance able to treat oral sepsis while a woman was pregnant and later after the birth of the baby complete the necessary treatment), under the general dental service dentists did not receive payment unless they certified that the patient was dentally fit. Dentures were supplied free by the local health authority under the priority dental service but not under the general dental service unless the patient was under twenty-one. It was generally agreed that these requirements of the general dental service were necessary for ordinary cases. There were, however,

suggestions that under the general dental service dentists should be able to provide and be paid for partial treatment prior to the patient's confinement. This treatment could be completed afterwards. It was also suggested that dentures should be available under the general dental service free of charge for the priority groups.

162. Although we have not found scientific evidence for the commonly expressed view that dental fitness was more necessary for expectant and nursing mothers than for other sections of the population, nevertheless we appreciate that it is very important that discomfort and pain during pregnancy should be eliminated and that good dental health is most desirable as a part of good general health. We also appreciate the educational value of dental attention at this time.

163. We consider, therefore, that the present priority dental service for expectant or nursing mothers should be continued. We hope that when the present plans to remedy the shortage of dentists have been realised, these women will get their full share of the improved dental service which should develop. We do not wish to make a recommendation regarding the provision of partial treatment or free dentures to expectant and nursing mothers under the general dental service but we would suggest that the apparent anomalies of the present situation should be investigated.

HOME HELP SERVICE

164. Under the provisions of section 29 of the National Health Service Act, 1946, a local health authority may make arrangements for providing domestic help to householders when for various reasons, including the presence of an expectant or nursing mother, such help is required. The local authority may recover from persons using this service such charges as it considers reasonable, having regard to the means of the persons concerned. The provision of a domestic help service is not mandatory on the local health authority but although the extent of the provision varies considerably all authorities do in fact provide one.

165. We had considerable evidence from many sources of the value of the home help service in maternity cases, whether the mother was confined at home or in hospital. There were strong criticisms of the inadequacy of the service in many areas and it was said that it was often not available when it was required during the weekends and evenings.

166. Most of the criticism of the service was directed at the charges for it made by the local health authority. It was suggested that these were unfair in that they increased the cost of a home, as compared with a hospital, confinement. Furthermore, it was said that in practice it was mainly from maternity cases that charges for domestic help were recovered because the husband was usually in full employment whereas the other users of the service were in general sick or aged persons whose means did not enable them to pay. There was a substantial demand that the home help service should be provided without charge for all maternity cases. One of our local authority witnesses, however, said that if any home help were to be provided without charge he preferred that it should be for old people rather than for maternity cases.

167. We consider that the home help service is an essential adjunct to the maternity services. In many areas the service is inadequate to meet the demand and we recommend a substantial increase in the number of home helps. We consider that if possible they should be made available at weekends and evenings though we appreciate that in many cases the husband would be at home at those times and a home help might not be necessary.

168. We have discussed whether home helps should be provided without charge for maternity cases. In coming to our conclusion we took into account that in the great majority of such cases the head of the family is able to contribute towards the local health authority charges. In cases where the income is below a certain level the local health authority has power to reduce or waive the charge. In these circumstances we have concluded that there would be no justification for providing maternity cases with home help on any different basis from that on which it is available for the other classes defined in section 29 of the Act.

MATERNITY AIDS IN HOLLAND

169. We were particularly interested in an account by one of the members of our Committee of the work he had seen of Maternity Aids in Holland. He was much impressed by the rôle they had played in assisting the mother and the family during the two weeks after delivery. In Holland some 78 per cent of all confinements took place at home. The Dutch Maternity Aids were usually young women over nineteen years of age whose educational standard would not make them suitable for training for higher nursing or midwifery work. They received a limited training, three months theoretical and twelve months practical, in such subjects as care of mother and baby, establishment of breast feeding, domestic science, hygiene, cooking, baby nutrition and laundry. They had lessons on midwifery and during their training attended a certain number of confinements. Fundamental to the success of this system was their sense of vocation and love of children, their commonsense and cleanliness, their ability to cook and to look after the mother, the baby and the other young children in the family. The Maternity Aids were not midwives and did not undertake deliveries. They usually went to the mother shortly after delivery and stayed for about ten days and lived with the family. The cost of the Maternity Aids was met from a State grant. Their work was supervised by the voluntary agencies which in Holland provided the midwifery service.

170. We appreciate that living conditions and traditions of maternity care in Holland are different from those in England and Wales and that the present state of employment might make more difficult any attempt to institute in this country Maternity Aids similar to those in Holland. Furthermore we are aware that the duties of the trained midwife in Holland and those of her counterpart in this country are not identical and that the provisions of the Midwives Act, 1951, relating to the attendance on women in childbirth might prove incompatible with the employment of Maternity Aids. Nevertheless we believe that such a service, if it could be provided as a supplement to the home help service, would be of great value and would perhaps do much to make it easier for those women who have their babies

at home. This could well be a field for a voluntary organisation to pioneer what might develop into a new service.

LOCAL HEALTH AUTHORITY MATERNITY HOMES

171 There were suggestions from several County Borough Councils that maternity homes, with or without resident staff, where confinements could take place attended either by a domiciliary midwife or by a general practitioner obstetrician should be provided by the local health authorities. It was thought that such homes, which would deal only with potentially normal cases, would be cheaper than hospitals and would provide a more convenient place for confinements than patients' homes.

172. Under existing legislation local health authorities have no power to provide maternity homes. In any case we consider that the establishment of local authority maternity homes, in addition to and separate from the maternity hospitals of the hospital service, would have the undesirable effect of creating two separate institutional maternity services and add to the problem of co-ordination.

REST HOMES FOR MATERNITY PATIENTS

173. Another suggestion was that there was a need for ante-natal and post-natal rest homes provided by local health authorities. We understand that experience has shown that such rest homes, when provided, have not been fully used and have proved uneconomical.

SELECTION OF CASES FOR HOSPITAL CONFINEMENT

174. We have referred in Chapter 6 to the role of the local health authority in determining whether social reasons exist which would make home confinements undesirable.

CONCLUSIONS AND RECOMMENDATIONS

- Local authorities to whom health service functions are delegated under the Local Government Act, 1958, should, in cases where the number of domiciliary confinements is small, consider making arrangements, in accordance with section 23 of the National Health Service Act, 1946, for the domiciliary midwifery service to be provided by the local Hospital Management Committee. (Paragraph 117.)

- Every woman accepted for home confinement should book both a midwife and a general practitioner obstetrician for her maternity care. (Paragraph 129.)

- The respective responsibilities of all those involved in maternity care should be understood and proper records should be maintained to ensure that co-ordination is achieved. (Paragraph 131.)

- The general practitioner obstetrician should ultimately replace the local authority medical officer in providing maternity care in local authority ante-natal clinics. (Paragraph 147.)

- The use of local health authority ante-natal clinics should, as far as general practitioners are concerned, be reserved for doctors on the obstetric list. (Paragraph 149.)

- Local health authorities should continue to provide premises and facilities for ante-natal clinics without charge to general practitioner obstetricians and to hospital medical staff holding outlying hospital clinics. (Paragraph 150.)

- An appointment system should be instituted in all ante-natal clinics. (Paragraph 151.)

- Health education and mothercraft instruction should be available for all expectant mothers. Local health authorities should, as necessary, provide instructors in health education in their own clinics, in the surgeries of general practitioner obstetricians and in hospital clinics. (Paragraphs 155 and 156.)

- The present priority dental service should continue to be provided. (Paragraph 163.)

- The home help service should be substantially increased but it should continue to be available for maternity cases on the same financial basis on which it is provided for other users. (Paragraphs 167 and 168.)

- We believe that a Maternity Aid service, similar to that in Holland, would be a valuable supplement to the home help service. (Paragraph 170.)

CHAPTER 8

MATERNITY MEDICAL SERVICES PROVIDED BY GENERAL PRACTITIONERS

Present administration

175. Under section 33 (2) of the National Health Service Act, 1946, regulations were made setting out the arrangements to be made by Executive Councils for the provision of a general medical practitioner service (including a maternity medical service) and the terms of service for the general medical practitioners. A doctor participating in the National Health Service is required to give his patients all proper and necessary advice and treatment. A practitioner may not accept a fee from the patient in respect of any service, including maternity services, which he gives to any of the patients on his list. He is not required (except in the case of an emergency) to give treatment involving special skill or experience not possessed by general practitioners as a class; nor is he required to give maternity medical services unless he has, by arrangement with his patient, undertaken to provide her with such services.

176. The maternity medical services under the National Health Service may be provided by a general practitioner obstetrician to any patient who applies to him. A doctor who is not a general practitioner obstetrician may provide maternity medical services, under the National Health Service, only for women who are on his general medical list of patients but not for others. He is, however, under no obligation to provide these services unless he so desires: if he does so his obligations are the same as those of a general practitioner obstetrician, but he receives a smaller fee.

177. Local obstetric committees were established in 1948 under the National Health Service Act, 1946. They consist of a consultant obstetrician, the Medical Officer of Health to the local health authority and two general practitioners experienced in obstetrics nominated by the local medical committee. The functions of the local obstetric committees are to review the obstetric experience of medical practitioners who wish to provide maternity medical services to patients in addition to those on their lists. Practitioners whose experience is approved are placed on what is known as the "obstetric list" which is reviewed by the committee from time to time. These doctors are known as general practitioner obstetricians.

178. In March, 1953, the Ministry of Health wrote to the Chairmen of Executive Councils saying it was known that local obstetric committees had sometimes been in difficulties over the criteria which they should apply to applicants for inclusion on the obstetric list. The Central Health Services Council had been asked for advice which was as follows:

- "(a) the existing machinery, based on the local obstetric committees, for the admission of doctors to the obstetric lists should be continued ;
- (b) in considering future applications for admission to the obstetric list local obstetric committees should be recommended to apply the criterion that the applicant should have held a six months' resident appointment in an obstetric unit ;
- (c) where a doctor wishing to practise midwifery fails to qualify under the criterion, local obstetric committees should be recommended to assist the applicant to obtain the necessary obstetric experience on the following lines :

the doctor should be required to seek additional experience in an obstetric unit. This should include within a period of six months not less than twenty normal deliveries ; attendance at not less than ten abnormal confinements ; and attendance at not less than ten ante-natal and two post-natal clinics. At the end of the period, a certificate from the consultant obstetrician in charge of the obstetric unit, to the effect that this work had been done satisfactorily, should be obtained ;

- (d) any criteria laid down should not be retrospective."

It was stated that the Minister was not proposing to prescribe any rigid criteria but he commended the advice of the Central Health Services Council to the local obstetric committees.

179. The Terms of Service for medical practitioners state that a doctor whether on the obstetric list or not who accepts a patient under the maternity medical services is obliged "to give an initial medical and obstetric examination and an examination at the thirty-sixth week of pregnancy, together with such other examinations and ante-natal care as he thinks necessary, or where necessary to attend at or in connection with abortion ; to attend her if summoned, at any emergency connected with the pregnancy ; to be present at the confinement if he thinks it is necessary or if he is summoned by the midwife ; and to give a medical and pelvic examination of the mother as near as may be to six weeks after the confinement, and in any case not later than twelve weeks thereafter, together with any necessary medical care of the mother and child for a period of fourteen days after the confinement." The doctor is responsible for calling in another doctor as an anaesthetist when necessary. The hospital and specialist services including domiciliary visits by

obstetricians and paediatricians are available at the doctor's request. In an obstetric emergency the service of an Emergency Obstetric Unit ("flying squad") is provided.

180. A general practitioner obstetrician who accepts a patient not on his own list is responsible for the patient's maternity care but the patient's family doctor remains responsible for her general medical care.

181. Ordinarily the doctor on the obstetric list must not employ a deputy or assistant to provide maternity medical services unless the obstetric experience of the deputy or assistant has been approved by the local obstetric committee. Exceptions in special circumstances may be made with the approval of the Executive Council.

182. Similar arrangements for maternity medical services may be made if the patient is to be confined at a nursing home or in a general practitioner hospital. A doctor should not provide maternity medical services for a hospital patient booked for confinement in hospital unless the hospital asks him to provide the ante-natal and post-natal care, or unless it is, in the doctor's opinion, inconvenient for the patient to attend the hospital for these services.

PRESENT REMUNERATION FOR MATERNITY MEDICAL SERVICES

183.

GENERAL PRACTITIONER OBSTETRICIANS

1. *Complete maternity services* as in paragraph 179 above—£7 7s. 0d.

2. *Partial maternity medical services*

(a) *Period I*

Where the doctor makes the initial ante-natal examination and gives medical care until the end of pregnancy, including an ante-natal examination at the 36th week or where necessary attendance at or in connection with abortion prior to the end of the 28th week—£3 13s. 6d.

(b) *Period II*

Where the doctor is responsible for attending at the confinement where necessary (including premature confinement after the 28th week), and for a medical and pelvic examination at or about the sixth week after confinement, together with such medical supervision of mother and child during the puerperium as required—£4 14s. 6d.

Other Services (where Period I or II payments are not applicable).

(a) Each ante-natal examination under an arrangement for giving maternity medical services—10s. 6d.

(b) Post-natal care only, including medical and pelvic examination—£1 1s. 0d.

(c) *Ante-natal care for hospital booked patients*

Where a doctor provides Period I services for a hospital booked patient, he may claim Period I fees. If a woman is unable to attend the hospital for ante-natal care because of some complication arising out of pregnancy, and calls in the doctor, payment may be claimed at the rate of 10s. 6d. for each time the doctor sees the patient in connection with treatment required, with an ordinary maximum of the full Period I fee.

(d) Emergency calls

If a doctor is called in (otherwise than by a midwife) to deal with a miscarriage of a woman who has not booked with him under the maternity medical services, he may claim a Period I fee.

If a doctor is called in for some other obstetric emergency, and does not undertake responsibility for the case beyond the emergency, he receives 10s. 6d. for each visit within the Period I fee. Similarly the Period II fee may be claimed for attendance at an emergency confinement if the patient has not made prior arrangements for maternity medical services and the doctor is not called in by a midwife.

If the doctor is called in by a midwife to attend a patient who has not made arrangements for maternity medical services with him, it is the responsibility of the local health authority (as part of their domiciliary midwifery arrangements) to pay any fee due to the doctor.

GENERAL PRACTITIONERS NOT ON THE OBSTETRIC LIST

A general practitioner not on the obstetric list who provides maternity medical services to a patient on his list is paid £5 5s. 0d. instead of £7 7s. 0d. for complete services and at five-sevenths of the rates specified above for corresponding services.

Work done under the maternity medical service

184. Appendix VII shows the services provided by practitioners under the maternity medical service for the year 1957. As can be seen, a total of 286,964 patients received complete maternity services; of these 279,062 cases were given care by general practitioner obstetricians and 7,902 by general practitioners. In 176,715 cases the doctor stated he was present at the confinement. The term "present at the confinement", however, should be interpreted in its widest sense, and in some cases may merely mean that the doctor visited the patient at some stage during labour or soon after the birth. The number of general practitioners in the National Health Service in England and Wales was in 1957 about 19,340, of which 14,400 were general practitioner obstetricians.

THE OBSTETRIC LIST

The evidence we received

185. We received a great deal of evidence both in favour of and against the obstetric list. Those witnesses who were opposed to an obstetric list thought that it discriminated between one doctor and another. They stated that the qualification and registration of a doctor declared his competence to practise midwifery and in any case he was liable to be called to a maternity case in an emergency. They recognised that some practitioners would not wish to do maternity work, and would be prepared under these circumstances to pass on their cases to another general practitioner. They had no objection to a voluntary obstetric list which would be a guide to the public and to midwives who sought medical aid. In the opinion of one witness a general practitioner's reputation with his patients was largely built on his maternity work. One group of witnesses thought the way to secure a better standard of midwifery in general practice was by improving medical

education rather than by having an obstetric list, and thought that, notwithstanding what had been said about qualification confirming competence, more opportunity was needed for experience and post-graduate education. They insisted on the recognition of two principles: namely the overall responsibility of the general practitioner for his own patient and the need for continuity of care of the patient. One witness wanted a list restricted to doctors who had held appointments on the obstetric staff of hospitals.

186. In favour of an obstetric list it was argued that midwifery required special skill and adequate practice and that there was insufficient domiciliary or general practitioner hospital work available for every general practitioner to acquire and maintain the skill to practise midwifery. We were told that the standard of some general practitioner work was questionable but from the "Report on Confidential Enquiries into Maternal Deaths in England and Wales 1952-1954" this appeared to be due to errors of omission rather than errors of commission. Other witnesses said that some doctors confined their ante-natal care to the minimum statutory two ante-natal examinations.

187. Varying evidence was given, however, on the number of confinements which was considered necessary to maintain midwifery skill. The lowest suggested number was 10 and the highest 50 cases per year, including attendance at the confinement. One witness thought that if a general practitioner obstetrician booked too many cases he would not be able to attend all the deliveries which required his presence. A survey was quoted which showed that one third of the general practitioners did not wish to practise midwifery, one third did it only because they felt that their patients expected it, and the remaining third practised it because they were really interested. In the opinion of several witnesses only those general practitioners really interested in obstetrics should practise it.

188. Evidence was given on the amount of domiciliary maternity work available for general practitioners. One witness thought that, if standards were to be maintained, participation in midwifery should be limited to 20 per cent of all general practitioners. We were told that only 12 deliveries a year would be available for each general practitioner if he attended the domiciliary confinements of patients on his general list. Of the 2,200 general practitioners in London in 1956, 1,283 did not undertake any midwifery.

189. Many of our witnesses said that admission to the obstetric list was granted too easily and that standards for admission were not uniform. They recommended the application of stricter conditions and considered that doctors should not be admitted to the list unless they had held a six-months' resident obstetric post after qualification. Some witnesses thought that in addition to this the possession of a diploma of obstetrics of the Royal College of Obstetricians and Gynaecologists was necessary. One witness suggested that attendance at a large number of cases in association with another doctor or as his assistant could be accepted as a satisfactory alternative qualification. It was also considered that only a general practitioner in a group practice should undertake midwifery and that if he did so his general medical list should be limited to 1,500 patients.

190. Further evidence was given of the need for a periodical review of the obstetric list. It was suggested that doctors who had not done enough

maternity work to maintain their skill should be removed from the list and that attendance at refresher courses should be a requirement for remaining on it. We were told that in Leicester in 1955, 107 out of 147 general practitioners were on the obstetric list and that they had each averaged about 4 deliveries a year. It was also said that in 1954 one twelfth of the general practitioner obstetricians in Kent did not practise midwifery, one third cared for less than 10 maternity cases each during the year, and a quarter cared for less than 20 cases each. In London in 1955, out of 515 general practitioner obstetricians, 216 did not undertake any maternity work and 124 general practitioner obstetricians and 256 general practitioners each undertook 5 maternity cases or less.

Our views

191. During recent years and because of the rapid increase of knowledge, the practice of obstetrics has become a specialised branch of medicine as have, for example, anaesthetics and ophthalmology. The realisation that maternal deaths could be prevented by good ante-natal care and better conduct of labour has accentuated the trend towards specialisation. The foundation of the Royal College of Obstetricians and Gynaecologists in 1929 emphasised that a specific qualification apart from general medicine and surgery was needed for consultant obstetricians. In 1930 local authorities were required under the Local Government (Qualification of Medical Officer and Health Visitor) Regulations to appoint medical officers with special experience of practical midwifery and ante-natal work. When the National Health Service came into being it was realised that, although all doctors were qualified to practise obstetrics, some were recognised by inclusion in the obstetric list as having special experience and were given extra remuneration for their skill.

192. Having carefully considered all the evidence submitted to us, we are entirely of the opinion that the practice of obstetrics requires special skill and experience and that there is not enough domiciliary maternity work available to enable every general practitioner to obtain and maintain the necessary standard of skill.

193. We have therefore decided to recommend that an obstetric list is necessary. In coming to our conclusions, we have noted that even witnesses who were opposed to an obstetric list agreed that, in order to remain competent, a doctor ought to attend a minimum number of maternity cases each year although the minimum suggested varied from 10 to 50. If, however, the present birth rate of about 16 per 1,000 population is maintained and the hospital confinement rate is raised to 70 per cent, as we have suggested in Chapter 5, a doctor can expect only about 5 cases a year for every 1,000 patients on his general medical list. This would give about 12 or 13 cases each year to each general practitioner and it follows from what we say in paragraph 196 that we consider this number to be insufficient to maintain skill.

194. We are of the opinion that the present obstetric list of 14,400 general practitioner obstetricians is not entirely satisfactory. In making this statement we wish to record that, while we realise that this might imply some criticism of the work of the local obstetric committees at the time of the introduction of the National Health Service, we recognise and appreciate the difficulties

under which they were working at that time. We consider that the time has now come to lay down a minimum standard for the admission to and the retention on the obstetric list.

195. We wish to endorse the advice given in 1953 by the Standing Medical and Standing Maternity and Midwifery Advisory Committees on criteria for admission to the obstetric list and consider that this advice, with the exception of their recommendation (c) referred to in paragraph 178, should be made mandatory on local obstetric committees. It was usual in the past to admit to the obstetric list doctors who had not held a resident appointment in midwifery. We do not think that this practice should be perpetuated, for in our opinion it does not afford the initial training and the continuous and complete experience in maternity care which we consider necessary. While recognising that for example a senior registrar in some other speciality, wishing to enter general practice as a general practitioner obstetrician, might find it difficult to revert to the status of an obstetric house officer in order to obtain the necessary midwifery experience, we do not feel that there would be any justification for allowing him, merely because of his greater experience in other branches of medicine, to gain admission to the obstetric list by any method other than that suggested below. The substitution of non-resident post-graduate experience for a resident appointment in obstetrics may, however, have to be accepted for practitioners who had previously been on the list and wish to be re-admitted. The same may be true for doctors in sparsely populated areas, but we would hope that the Medical Practices Committee would not appoint a new doctor to such an area who had not held a post-graduate resident obstetric appointment. We recommend that a six months' resident appointment in an obstetric unit under the control of a consultant obstetrician should be the normal criterion for admission to the obstetric list. We understand that there are sufficient hospital posts available to enable this recommendation to be fulfilled. We do not think that there should be any restriction on the number of doctors admitted to the list and we consider that the request of any doctor to have his name put on it should be granted, provided he is qualified according to our recommendations.

196. As we hold the view that it is necessary for a general practitioner obstetrician to have continuing experience, we consider that local obstetric committees should review the obstetric list periodically at three year intervals and that criteria should be laid down for retention on the obstetric list. We therefore recommend that to remain on the obstetric list a doctor should, over the preceding period of three years, have had at least 60 complete booked cases, of which he should have attended the deliveries of at least half. This number would include cases for which he was responsible in a general practitioner unit. We realise that in a few special areas where there is an unusually small number of births this might be difficult to achieve. We consider that where for special geographical reasons this average cannot be achieved, even when the midwifery work is concentrated in the hands of one or two practitioners, a lower number might be accepted provided the doctor also takes refresher courses, approved by a medical school, at intervals of not more than five years. Where a general practitioner obstetrician provides full ante-natal care for hospital booked patients, this might be taken into account in making a decision in special circumstances for his retention on the obstetric list.

197. We consider that the local administration of the list should remain with the local obstetric committees. They should retain their present constitution except that provisions should be made for the local authority member to be either the Medical Officer of Health or another medical officer representing the local health authority. We recommend that there should be some procedure for appealing against a decision of the local obstetric committee and this should be similar to that for appeals against decisions by the local medical committee on matters involving primarily professional considerations. The membership of the appeal body should be different from that of the local obstetric committees and the medical members should include at least one consultant obstetrician drawn from another area.

198. We recommend that the Minister should initiate a periodical review by the Standing Medical and Standing Maternity and Midwifery Advisory Committees of the criteria for admission to and retention on the obstetric list. We recommend that the Minister should consider making these criteria mandatory on the local obstetric committees.

LIMITED MEDICAL LISTS FOR GENERAL PRACTITIONER OBSTETRICIANS

199. Some of our witnesses suggested that the size of the general list of a general practitioner obstetrician should be limited. We have decided not to make any recommendation on this as we consider it inevitable that if our hopes are realised his increased maternity work would provide a general practitioner obstetrician with a material part of his income. This would probably lead to a reduction of his ordinary list, to his taking a partner or assistant, or to his entering into a group practice.

LOCUMS AND DEPUTIES FOR GENERAL PRACTITIONER OBSTETRICIANS

200. We consider that a deputy or a locum of a general practitioner obstetrician should have obstetric experience sufficient to gain admission to an obstetric list. We realise that in a few rural areas this might not always be possible.

GENERAL PRACTITIONER OBSTETRICIANS WHO ARE AT PRESENT ON THE OBSTETRIC LIST

201. We recommend that the present obstetric list should be accepted as it stands so that there should be no necessity for general practitioner obstetricians already on the list to apply for admission. They should, however, fulfil the criteria for remaining on the list at the first review which we recommend should occur at the end of three years.

GENERAL PRACTITIONERS WHO ARE NOT AT PRESENT ON THE OBSTETRIC LIST

202. We realise that a general practitioner cannot be debarred from practising midwifery whatever recommendations might be made about fees payable under the maternity medical services. This does no more than recognise that the ordinary training of every doctor entitles him to practise midwifery but in so far as he undertakes it without "special skill or experience not possessed by general practitioners as a class", there appears to be no reason

why he should be remunerated for such maternity work any differently than for any other advice and treatment he can give as a general practitioner. The existence of an obstetric list indicates a recognition that the standards required in present day midwifery call for special skill and continuing experience. We therefore consider it a reasonable conclusion that special fees for maternity work should be payable only in respect of the exercise of special skill as recognised by a doctor's inclusion in the obstetric list. It would be open to a general practitioner not on the obstetric list to decline to undertake maternity care even if a woman expressed a strong desire to be attended by him, in the same way as he would be expected to decline to undertake other forms of medical treatment for which he had not a recognised special skill. As a doctor he would naturally respond to a call to a maternity case in an emergency as he would to any other medical emergency.

PAYMENT OF GENERAL PRACTITIONER OBSTETRICIANS

203. Most of the evidence we received indicated that the present remuneration for maternity medical services was inadequate and we are in agreement with this. A few witnesses suggested that payment for "a minimum number of examinations" should be abolished and replaced by payment for items of service. If our recommendations are accepted a more uniformly high standard of work will be required from the new general practitioner obstetrician, who will be exercising special skill and doing more and better quality work. We believe that his remuneration for maternity services should be substantial and that this should be at a rate for each case as at present. As we have said we would hope that the fees received for his midwifery work by the general practitioner obstetrician would become a material part of his income.

204. Some witnesses pointed out that division of payment into three parts (see paragraph 183) meant that a general practitioner who referred his patient to hospital before she went into labour received only a part fee, i.e., Period I, whereas if he had kept her until she was in labour, he would have received the complete fee. While appreciating that an unscrupulous doctor could accept a patient knowing full well that she would in due course have to be referred to hospital, we consider that the general practitioner obstetrician who undertakes to provide maternity medical services should receive a full fee even if the patient is subsequently transferred to hospital. It is important to afford the greatest protection to the patient and ensure that she is transferred to hospital as early as her condition warrants, and we consider that sufficient check could be kept on any habitual abuse if the doctor had to give reasons for transfer of a patient to hospital on the claim forms submitted to the Executive Council. These could be examined by the Executive Council if necessary in co-operation with the local medical committee or local obstetric committee. We wish to stress that abnormal cases or cases with an abnormal past history would in any event probably have been booked for hospital confinement.

205. An appropriate proportion of the full fee will, of course, need to be paid to a general practitioner obstetrician who undertakes ante-natal care for hospital booked patients, or for patients who move to another area, or where, after the first examination, they are found to be unsuitable for home confinement.

206. When the Midwives Act, 1902, made it compulsory for a midwife to call for medical aid, no provision was made for the payment of the doctor's fee. This led to difficulties and although in cases of need the Board of Guardians could assist, this was rarely done. In consequence the Midwives Act, 1918, made it a duty of the local supervising authority to pay the fee of the doctor. When the National Health Service Act, 1946, was passed the responsibility for the payment remained with the local health authorities.

207. We recommend that it would be more satisfactory if payment of medical aid fees were made by the authorities responsible for the payment of fees for maternity medical services and not by local health authorities. As we are recommending that every mother should be encouraged to book a doctor under the maternity medical services, we consider that the number of payments for medical aid calls by midwives for patients who have not booked a doctor will gradually lessen.

MATERNITY CARE REQUIRED OF GENERAL PRACTITIONER OBSTETRICIANS

The evidence we received

208. There was general agreement among our witnesses that the minimum of two ante-natal and one post-natal examinations required of a general practitioner as a condition of service should not be regarded as the minimum amount of care necessary. Suggestions were made that five, six or seven examinations should be the minimum. Other witnesses thought that no minimum should be laid down by regulation for payment purposes, as some women needed more care than others and a doctor should not be penalised in cases where a woman refused or made it difficult to be examined or booked late in pregnancy.

209. We received varying evidence on the need for the attendance of the general practitioner obstetrician at the confinement. One witness considered it unnecessary in nine out of ten cases, while others thought that doctors should attend more confinements than at present. Another stated it was important that the doctor should visit the patient early in labour in order to give her confidence.

210. We received some evidence on the inadequacy of the present requirements for post-natal examination: a few witnesses considered that an examination five to six weeks after delivery was not the best time for carrying out a post-natal examination. The majority, however, agreed that the present requirement of an examination as near as may be to six weeks after the confinement was satisfactory.

Our views

211. We consider that it is unnecessary for us to define precisely the content of ante-natal care but we agree that only two ante-natal examinations by a doctor are inadequate. We would endorse the advice given by the Standing Maternity and Midwifery Advisory Committee as laid down in the memorandum on "Ante-natal Care Related to Toxaemia", which is reproduced in full in Appendix II. We are concerned that the duplication or

omission of examinations by doctor, midwife and hospital should be avoided and consider that much depends on an adequate system of notification and co-operation. (See Chapter 11). The midwife and the doctor are both under an obligation to ensure that adequate ante-natal care is given. It should, however, be the responsibility of the general practitioner obstetrician to make certain that ante-natal care of the standard laid down in the memorandum on "Ante-natal Care Related to Toxaemia" is provided whether by himself or by arrangement where appropriate with the domiciliary midwife or the matron of the maternity unit. As we have stated in paragraph 129 we consider that the responsibility for ensuring that ante-natal care is provided should be placed on the general practitioner obstetrician. It is very important, however, that the general practitioner obstetrician should not delegate *all* the ante-natal responsibilities either to the domiciliary midwife or to the maternity unit. We think that it is impracticable to recommend that the general practitioner obstetrician and the midwife should always see the patient together but consider that there should be the closest co-operation between them. We suggest that ante-natal examinations should not normally be given in the ordinary surgery session.

212. We are of the opinion that a general practitioner obstetrician should, whenever possible, attend all domiciliary confinements, to safeguard the mother and the baby against unforeseen emergencies, to give the patient confidence and incidentally to maintain his experience. Ideally, he should visit early in labour and then be present for the delivery. The conduct of a normal confinement is the joint responsibility of the doctor and midwife. We consider that the present regulations under which a doctor providing maternity medical services should give any necessary care of the mother and child for a period of fourteen days after confinement should continue. We have earlier suggested that medical aid fees should be paid by the authority who pays for maternity medical services. We consider that the apparent anomalies between the respective periods of care indicated in the regulations governing medical fees and those governing the maternity medical services should be reviewed.

213. We are satisfied that the statutory post-natal examination "as near as may be to six weeks after delivery" is adequate for normally healthy patients. As each patient has to be treated individually, it is impossible to specify any common standard.

SERVICES TO ASSIST GENERAL PRACTITIONER OBSTETRICIANS

214. Various witnesses recommended services which should be available for the help of general practitioner obstetricians. These services included consultant advice and assistance; "flying squads"; consultant anaesthetists for domiciliary confinements; the services of hospital pathological laboratories; the services of hospital X-ray diagnostic departments; facilities for physiotherapy; facilities for venereal disease testing; equipment for blood-taking and intravenous infusion, and standard records. One witness also suggested that general practitioners should be supplied with intravenous transfusion sets and gas and air machines, although another witness said that he had used intravenous fluid in only two cases out of 150 cases in a year. We are in agreement with our witnesses that readily available consultant advice and

assistance, including an emergency obstetric service ("flying squad"), access to the services and facilities of the hospital pathological laboratories, and supplies of sterilised equipment for blood taking and intravenous infusion of fluids, should be provided. We understand that these services are generally already available.

THE GENERAL PRACTITIONER OBSTETRICIAN AND THE FAMILY DOCTOR

215. The present regulations provide that a patient's family doctor remains responsible for her general care while she is receiving maternity care from a general practitioner obstetrician. We consider that a general practitioner has overall responsibility for all his patients whether they are delivered by a general practitioner obstetrician or in a hospital: therefore with the patient's consent, he should be informed of any abnormalities and illnesses which may occur. Furthermore, with the patient's permission, the general practitioner obstetrician should notify the general practitioner of any maternity booking he has made of the latter's patient and of when he has discharged her from his care. Similarly, the general practitioner should inform the general practitioner obstetrician of any infectious illness in the family. Many of the difficulties of the relationship between the general practitioner obstetrician and the general practitioner might well resolve if the present trend towards group practice continues.

THE GENERAL PRACTITIONER OBSTETRICIAN AND THE MIDWIFE

216. Although we received some evidence that there had been a certain amount of rivalry between doctors and midwives when the National Health Service Act, 1946, had first been introduced, this seems to have been due mainly to misunderstanding between them of their respective duties and it was generally agreed that they were now working in closer co-operation. We consider that a woman should book both a general practitioner obstetrician and a midwife for her confinement as each has an important part to play in ensuring that she receives the best of care. It is essential that there should be close co-operation between doctor and midwife; each being aware that the other has been booked and of their respective responsibilities.

THE GENERAL PRACTITIONER OBSTETRICIAN AND THE LOCAL HEALTH AUTHORITY

217. The local health authority maternity and child welfare departments can be of considerable help to a general practitioner obstetrician and it is important that he should be aware of the extent of services they provide, so that he can advise his patients to take full advantage of them. The use of local health authority clinics by general practitioner obstetricians is described in detail in Chapter 7.

THE GENERAL PRACTITIONER OBSTETRICIAN AND THE HOSPITAL SERVICE

218. We feel that it is most desirable that there should be a firm link between the general practitioner obstetrician and the hospital obstetric team.

We think that general practitioner obstetricians should be given the opportunity to work in hospital. When the present maldistribution of registrars has been corrected it should be possible to offer general practitioner obstetricians hospital posts, either paid or honorary.

219. The holding of meetings at hospitals where local authority staff and general practitioner obstetricians can take an active part would also help to encourage a closer liaison between all members of the obstetric team. These points are discussed more fully in Chapter 10, together with the suggestion that the payment for maternity medical services might be made by the hospital authorities rather than by the Executive Councils as at present.

GENERAL PRACTITIONER MATERNITY BEDS

220. The provision and control of general practitioner maternity beds are described in detail in paragraphs 251 to 261. We consider that such beds can make a very valuable contribution to the maternity services of the country and if utilised to their best advantage, can give to the patient many of the benefits both of home and hospital confinement.

CONCLUSIONS AND RECOMMENDATIONS

- The practice of obstetrics requires special skill and experience. There is not enough domiciliary maternity work available to enable every general practitioner to obtain and maintain the necessary standard of skill. (Paragraph 192.)

- The obstetric list should be continued. More uniform criteria should be applied for admission to and retention on it. (Paragraphs 193 to 197.)

- A six months' resident appointment in an obstetric unit under the control of a consultant obstetrician should be the normal criterion for admission to the obstetric list. (Paragraph 195.)

- In order to remain on the obstetric list, which should be reviewed every three years, a doctor should, over the preceding period of three years, have had at least 60 complete booked cases of which he should have attended deliveries of at least half. (Paragraph 196.)

- Local obstetric committees should continue. An appeals procedure should be adopted. (Paragraph 197.)

- There should be a periodical review of the criteria for admission to and retention on the obstetric list. These criteria should be made mandatory on local obstetric committees. (Paragraph 198.)

- The present obstetric list should be accepted and should be reviewed at the end of three years. (Paragraph 201.)

- Payment for maternity medical services should be for the exercise of special skill and experience as recognised by a doctor's inclusion in the obstetric list and such payment should be made only to doctors on the obstetric list. (Paragraph 202.)

- Except in the circumstances mentioned in paragraph 205, a general practitioner obstetrician who undertakes to provide maternity medical services should receive the full fee even if the patient is subsequently transferred to hospital. (Paragraph 204.)

● Medical aid fees, at present paid by local health authorities, should be paid by the authorities responsible for payment of fees for maternity medical services. (Paragraph 207.)

● We endorse the advice set out in the memorandum on "Ante-natal Care Related to Toxaemia". We consider that the general practitioner obstetrician should be present at the delivery whenever possible; that he should give any necessary care to the mother and child for a period of fourteen days after confinement; and that a post-natal examination should be carried out as near as may be to six weeks after delivery. (Paragraphs 211 to 213.)

● A general practitioner obstetrician and a midwife should be booked for every domiciliary confinement and there should be close co-operation between them. (Paragraph 216.)

CHAPTER 9

MATERNITY SERVICES PROVIDED BY HOSPITAL AUTHORITIES

Present arrangements

221. Under Part II of the National Health Service Act, 1946, the Minister is charged with the duty of providing hospital and specialist services "to such an extent as he considers necessary to meet all reasonable requirements". These services include hospital accommodation; medical, nursing and other services required at or for the purposes of the hospital; and the services of specialists at a hospital, a clinic, a health centre, or if necessary on medical grounds, at the home of the patient.

222. The day-to-day administration of the non-teaching hospitals is the responsibility of Hospital Management Committees each covering either a group of hospitals or a single hospital. They are responsible for the appointment and the payment of all the staff employed at their hospital except the senior medical and dental staff. The Hospital Management Committees are appointed by 14 Regional Hospital Boards who are responsible for the planning and co-ordination of the hospital and specialist services and for the general supervision of the administration of the services in their areas. They appoint and pay the senior medical and dental staff, allocate the maintenance moneys to Hospital Management Committees and approve their expenditure. They also have other duties, such as administering the blood transfusion and mass radiography services. The 36 teaching hospitals are each administered by a Board of Governors who combine the functions of a Regional Hospital Board and a Hospital Management Committee. There is one teaching hospital in each provincial Regional Hospital Board area, the rest are in the Metropolitan regions.

223. Of the 737,704 births notified during the year 1957, 476,783 births occurred in hospitals, representing an institutional confinement rate of 64.6 per cent. From a total of 19,580 staffed beds in the National Health

Service there were 520,170 discharges, which included women who were discharged before labour, those admitted for ante-natal care but who remained in until after confinement, those admitted in labour, and those admitted as emergencies following labour elsewhere. During the past four or five years the hospital confinement rate has remained practically stationary. There was an increase in the birth rate in 1957 together with a slight increase in the number of patients admitted for ante-natal care despite a more or less constant number of staffed beds, so that the number of patients admitted to each bed in the year has been increased by diminishing the length of stay of each patient. Many of the criticisms of the maternity hospitals which we received were concerned with overcrowding and shortage of beds. These points have already been discussed in general in Chapter 5. We are therefore confining this chapter to more detailed comments upon the hospital and specialist services.

BOOKING ARRANGEMENTS FOR PATIENTS NEEDING HOSPITAL CONFINEMENT

Our views

224. Mention has already been made of the evidence we received showing the tendency of some hospitals to overbook, often without a strict selection of cases. (See paragraph 65.) We consider that patients in the priority classes already described should be admitted to a hospital or where appropriate to a general practitioner bed. Those cases which require a bed on social grounds should always be referred to the local health authority for assessment. We further recommend that general practitioners who consider that their patients need beds on social grounds only and where there are no medical reasons for admission to hospital should refer them in the first instance to the local health authority. The local health authorities in turn should notify the hospitals in writing of the reasons for recommending hospital confinements, so that should it become necessary to discharge patients early, the hospitals will be aware of the home circumstances of the patients. As already stated we received evidence that booking was often left to junior medical staff who were unaware of the full range of domiciliary and general practitioner services and we consider that any cases where there is an element of doubt should be referred by the junior medical staff for consultant opinion. In any case, a woman referred to hospital by a general practitioner obstetrician should be seen by a consultant obstetrician. We consider that if there are any beds remaining after beds have been allocated to patients in the priority groups, including patients with social needs and those requiring emergency admission, these might then be allocated on a "first come, first served" basis. (See paragraphs 70 and 71.) We are of the opinion that it would be impracticable for us to suggest a time limit for booking at hospital, for instance that all priority cases should book before they reach a certain month in pregnancy. Unmarried mothers and women moving into the area who have medical or social needs for hospital admission may not be able to book until very late in pregnancy. We therefore consider that each hospital should work out a system which would incorporate our recommendations as best adapted to its individual needs.

225. It has been the practice in the past for many hospitals to book patients following direct application by the women themselves. We consider that although it is preferable for a patient to be referred to hospital by her

doctor occasions will arise when a hospital should be able, subject to the provisos already made, to book a patient who applies directly to them for admission. The hospital, with the patient's consent, should inform the family doctor that his patient has been booked.

226. Some evidence we received suggested that there was a misapprehension that a woman had no choice of hospital. Maternity hospitals like other hospitals are free to take patients from any area.

ANTE-NATAL CARE GIVEN BY HOSPITALS

Present arrangements

227. At present various methods of arranging ante-natal care are used by the hospitals. Some hospitals run their own clinics and take the entire responsibility for their own patients; others delegate part of the ante-natal care either to a local health authority or to a general practitioner although usually only normal cases are thus referred for interim care. Some hospitals hold special sessions at local health authority clinics using their own staff; others co-operate with the local health authorities to provide joint sessions.

The evidence we received

228. Several witnesses pressed for efficient appointment systems at hospital ante-natal clinics in order to avoid much of the unnecessary waiting. Others complained that the clinics were overcrowded, too busy, had insufficient seats for patients and relations and lacked privacy for patients. It was widely alleged that hospitals did not take adequate steps to follow up "defaulters" i.e., those who failed to attend ante-natal clinics. It was suggested by some witnesses that all the interim ante-natal care for hospitals could be undertaken by general practitioners. The opposite view was expressed by others who suggested that for the convenience of patients living far from the hospital, the local health authority clinic should be staffed and run by the hospital so that its duties were not delegated either to the local health authorities or to the general practitioner obstetricians. Some complaints were made to us that hospitals did not provide comprehensive health education.

Our views

229. We consider that an efficient appointment system should be adopted in all ante-natal clinics and that the number of patients seen at each session by individual doctors and midwives should be small enough to enable the mother to discuss her problems with them. Hospitals should take prompt measures to follow up those who fail to attend and should endeavour to make every use of both the local health authority staff and general practitioners to carry this out for them. We consider that whether hospitals undertake all the ante-natal care for their own patients or delegate some of their responsibilities will depend upon the local circumstances and each hospital should decide which system or systems are best suited to its particular needs. We are of the opinion that interim ante-natal care provided under the maternity medical services should be undertaken by general practitioner obstetricians and not by general practitioners, the hospitals remaining responsible for ensuring that care is being given. The use of co-operation cards is discussed in Chapter 11. The adoption of our proposals for a new type of general practitioner obstetrician, who will work in the local health authority clinics

and have close liaison with the hospital, may make it unnecessary for hospitals to provide outlying clinics, because the general practitioner obstetricians would be able to take over much of the ante-natal care of the patients booked for hospital confinement. We consider it important that mothers should not be deprived, because of their place of confinement, of the services which they need. Hospitals, which due to lack of space or staff are unable to provide health education facilities themselves, should make sure that the mother is aware that she may if she wishes attend classes which are provided by the local health authority. Some hospitals arrange for the local health authority health visitors to attend ante-natal clinics so that they may get to know the mothers and assist the midwives in mothercraft and other health teaching.

PROVISION OF ANTE-NATAL BEDS IN HOSPITAL

230. The evidence we received endorsed the view expressed by the Standing Maternity and Midwifery Advisory Committee in the memorandum on "Ante-natal Care Related to Toxaemia" that the number of ante-natal beds in an area should be related to the total number of births in the area served. A few witnesses gave evidence of a shortage of ante-natal beds in their districts.

231. We found it extremely difficult to obtain any reliable estimate of the number of beds required for ante-natal care because much depended upon local conditions including the general state of the health of the population. We recommend that ante-natal beds over and above those needed for lying-in, should be provided for some 20 to 25 per cent of confinements in the country as a whole although we realise that in practice the number would vary considerably in different areas. We consider it very important that hospital authorities should give priority to the provision of ante-natal beds and that these beds should be reserved solely for ante-natal patients to ensure that the beds are available when needed. Hospitals should not include ante-natal beds when booking patients for delivery.

ARRANGEMENTS FOR THE RECEPTION AND CARE OF PATIENTS WHILE IN HOSPITAL

The evidence we received

232. We received a general complaint that there was in many hospitals too little regard for the personal dignity and emotional condition of women during pregnancy and childbirth. It was in this respect that the hospital as a place of confinement was compared most unfavourably with the home. It was said that at home the mother was the centre of attraction while in hospital she was treated rather casually. The hospital and labour wards were said to be unfamiliar and sometimes frightening to a woman, and witnesses thought that she should, during the ante-natal period, be shown where she would be delivered and be introduced to the ward and the labour ward staff. Several witnesses stated that women were left too long alone in labour, some ascribing this to shortage of staff, others to lack of understanding. It was suggested that a relation, if willing, perhaps her mother or her husband or both, should stay with the patient, although some witnesses were opposed to this idea. It was also alleged that the staff were sometimes too busy to bother about analgesia. Witnesses complained of noise and bustle and disturbance from other women in the wards preventing sleep

and some asked for smaller wards or single rooms. Others said that women did not like to be left alone. When discussing the lack of mothercraft teaching several witnesses said that in hospital in particular mothers were given too little experience in handling their babies. Some witnesses favoured "rooming-in" as overcoming this problem, while others said that even with "rooming-in" a satisfactory relationship between mother and baby could not be established in hospital. Other suggestions made were that women who had lost babies should be segregated from mothers with babies and that visiting times should be more flexible, so that, for example, husbands on shift work would be able to visit their wives.

Our views

233. Most, but not all of this evidence was given by the women's organisations, much of it from mothers who had had experience of delivery in hospital. We must emphasise, however, that the majority of women appeared to be satisfied with the maternity services and the evidence quoted was only from those who criticised. We consider that many of these points raise the question of hospital planning and we recommend that maternity hospitals should be organised in self-contained units of such a size that one sister can be in charge of both lying-in and labour wards and if possible in charge of the ante-natal beds as well. This would help to avoid the undesirable strain of continuous labour ward duty in units which are so large that a special labour ward staff is required. This strain would be even greater if hospitals were compelled to discharge patients early in order to increase admissions and therefore the number of confinements. It appears from the conflicting evidence we received on single wards that what is really wanted is flexibility of planning to allow some women to have company and others privacy. One of the reasons for lack of mothercraft training in hospital is lack of staff and space. We consider that despite these difficulties a mother should be given every possible opportunity in hospital to get to know and manage her baby. We realise that the question of visiting times is a general problem which is not confined to maternity hospitals but we advocate that hours of visiting should be as flexible as possible. In particular we would recommend that facilities should be given for the patient's husband, mother or near relation to be with her, at least during the first stage of labour.

234. We would like to emphasise that every attention should be paid in hospital to the mental and physical care and well-being of women during pregnancy and childbirth so that hospital confinement should in this respect achieve as nearly as possible the atmosphere of home confinement.

CARE OF BABIES IN HOSPITAL

The evidence we received

235. Evidence was given that infant mortality in the first year of life had been halved in the last twenty years, but that deaths under one month had declined to a lesser extent and the stillbirth rate had remained more or less static. These rates showed wide regional variations but the rates in the country as a whole were worse than those of Australia, Holland, New Zealand and Sweden. (See Chapter 3.) It was suggested by some witnesses that breast feeding improved an infant's chances of good physical and

emotional health although other witnesses considered that there was no difference in this respect between breast-fed and properly supervised artificially-fed infants. It was suggested to us that there should be better co-operation between the obstetrician and the paediatrician before confinement; that there should be paediatrician on the staff of every maternity hospital to share the clinical and administrative responsibility for the prevention of illness in babies; that there should be premature baby units and special ambulances in every area; and that these units could be used not only for premature babies but for other difficult cases not requiring isolation on grounds of infection. There should be immediate hospital admission for certain types of acute respiratory infection among babies born at home. Another witness considered that, during the puerperium, too much attention was given to the mother and too little to the baby. It was said that on investigation big variations in infant mortality were shown to exist between one hospital and another and in the opinion of the witness this was avoidable, being caused by overcrowding and staff shortage. It was also suggested that the space provided for "rooming-in" and for nurseries was often inadequate.

Our views

236. We wish to emphasise that we are of the opinion that the present peri-natal mortality rate could be lowered by a better maternity service, in particular by more careful ante-natal care.

237. We consider that the visit by a paediatrician under the domiciliary consultation arrangements is preferable to a flying squad for babies or to their emergency admission to hospital. We agree that while every hospital needs to make some provision for premature babies born in hospital, a better standard of care can be obtained if cots are centralised in units of such a size that it is practicable to provide special staff for them. These cots should be used for the admission from the domiciliary district and from other hospitals of premature and other babies requiring special care.

238. We recommend that premature baby units with adequate space and sufficient in number to cover the whole country should be provided. We consider it most important that a mother in premature labour should if practicable be transferred before delivery to a hospital which has a premature baby nursery. A number of special cots will be necessary for transporting babies to hospital when required but we do not consider special ambulances are necessary for this purpose.

INFECTION IN HOSPITAL

239. This has already been mentioned in paragraph 54. There was a widespread concern over the amount of infection in maternity hospitals which many of our witnesses considered was increased by shortage of staff, quicker turnover and overcrowding. We would like to make it clear that we received no evidence that the number of cases of severe puerperal sepsis, for example haemolytic streptococcal infections, such as had caused the high maternal mortality rates in the past, was increasing. The infections causing concern were primarily of a different type and affected infants and sometimes caused breast sepsis in mothers. The infections were mainly

minor which very occasionally became dangerous: outbreaks even though of a minor nature do, however, cause serious administrative difficulties and may lead to the closing of maternity wards. We received no specific evidence to show that minor infections were less prevalent at home but these, in any case, only affect one mother and one child so that the danger of spread is consequently less. Some of our witnesses prophesied that in future, with the increase in the number of drug-resistant strains of staphylococci, the problem of infection was likely to become worse. We ourselves find it impossible to comment on this in view of the remarkable changes in virulence which have occurred in certain strains of bacteria.

DISCHARGE OF MOTHERS FROM HOSPITAL

240. Reference has already been made in paragraph 81 to the early discharge of patients from hospital. It should be the duty of the hospital, with the patient's consent and before discharging her, to ensure that the mother's family doctor will accept responsibility for her care and that her home is suitable. It is not sufficient to consult the wishes of the woman herself. It must be recognised that women admitted to hospital on medical grounds might also have adverse home conditions. A home not suitable for delivery of the patient might not be suitable for her nursing care during the puerperium.

RECORDS AND CLINICAL REPORTS

241. There was a general recommendation from our witnesses, with which we are in agreement, for a standard co-operation card. We refer to this in Chapter 11. We also consider that, despite the cost, the publication of hospital clinical reports should be encouraged and the reports should be extended to cover domiciliary practice so that a review of the results of the whole area would be possible. This could be an appropriate field for co-operation between the hospital authority, the local health authority and the general practitioners.

CLINICAL MEETINGS

242. Recommendations were made that there should be opportunities for discussions between general practitioner obstetricians, the consultant obstetricians and the medical officers on the staff of the local health authority. We consider that meetings held regularly to discuss the clinical problems and the work done in both the domiciliary and hospital practice in an area would be very useful and should be encouraged. (See paragraphs 312 to 315.)

EMERGENCY OBSTETRIC SERVICES (" FLYING SQUADS ")

243. A few of our witnesses mentioned the emergency obstetric services (" flying squads ") provided by hospital authorities. These witnesses were mainly concerned that the service should cover the country adequately. Two specific observations were made; one that midwives were not allowed to summon the emergency service on their own responsibility; and the other that flying squads were sometimes sent out in charge of junior medical officers below registrar status.

244. We were particularly interested in the description given to us by the Newcastle Regional Hospital Board of the administration of their flying squad services. We understand that the team might have to travel as far as 60 miles from Newcastle into the rural parts of the region but the Board's experience showed that it was better to base it on a large centre and to equip outlying hospitals with plasma for transfusion, rather than to try to organise flying squads within one hour's journey from the patient. They thought the staff should be of a senior grade and work from a hospital large enough to have sufficient medical staff to cover it while the flying squad was away. They also considered that the service needed to be in fairly constant practice to maintain efficiency.

Our views

245. In our opinion the most important essentials for a good emergency obstetric service are that there should be sufficient flying squads to cover the country as a whole; that they should be properly staffed; and that adequate transport should be available. Equipment for resuscitation should be kept in local hospitals and should be available to general practitioner obstetricians pending the arrival of the flying squad. We recognise that there are great difficulties in rural areas as, for example in parts of Wales, in arranging both for the flying squad to respond to distant calls and in ensuring that an adequate cover of senior obstetric staff is left at the hospital. We wish to stress the need to ensure that doctors and midwives know of the service and how to obtain it. In extreme emergencies, a midwife is already in fact able to call the flying squad at the same time as she calls for the general practitioner obstetrician although this is not always known. We wish to emphasise that a flying squad should include a consultant obstetrician or a deputy not below registrar status. We further consider it should be the responsibility of the hospital to see that adequate transport is available for the staff and equipment, and we hope that the local health authorities will co-operate with the hospitals by providing ambulances or "sitting-case" cars on a repayment basis.

HOSPITAL DISTRICTS

246. The implications and evidence concerning the possibility of hospitals running a district midwifery service are discussed in paragraphs 117 and 300. We were told of the problems of those teaching hospitals which needed a domiciliary midwifery district to provide midwifery training for medical students and for pupil midwives. We were informed that there was a reluctance on the part of some local health authorities to help in the provision and maintenance of these facilities. Another difficulty which was likely to increase was created by the diminishing number of "midwife only" cases and it was thought that it would sometimes be difficult to bring general practitioner obstetricians into a scheme for the training of medical students.

247. We consider that the education of medical students in domiciliary midwifery is very necessary and that the local health authorities and general practitioner obstetricians should do all they can to co-operate with the teaching hospitals in maintaining the necessary facilities and extending them where they are insufficient.

HOSPITAL BOARDING CHARGES

248. It was suggested that the hospital service was provided for those who required it for medical or social reasons and that those who used it for other reasons should pay boarding charges. We do not agree with this suggestion for although hospital confinement is probably less expensive to the mother, the difference in the cost to the community between hospital and home confinement is not as great as is generally assumed.

CO-OPERATION BETWEEN THE HOSPITALS AND THE GENERAL PRACTITIONERS

249. We believe that a general practitioner has an overall responsibility for the welfare of his patient and in any case he is likely to be called in during an emergency. We consider therefore that, with the patient's consent, the hospital should inform the family doctor that the patient has been booked and of any abnormality which requires treatment, rest at home, or may be such that he might have to give emergency treatment. The maternity hospital should, with the patient's consent, notify the family doctor of the discharge of any of his patients.

CO-OPERATION BETWEEN THE HOSPITALS AND THE LOCAL HEALTH AUTHORITIES

250. The local health authority should, with the patient's consent, be notified of all women discharged from hospital in order to allow them to arrange for the health visitor to visit as soon as possible after the mother arrives home. If the mother is discharged early it is essential that the local health authority should be informed before she leaves hospital so that they can arrange for the necessary home care. (See paragraph 133.)

GENERAL PRACTITIONER MATERNITY BEDS

The evidence we received

251. A number of our witnesses expressed views concerning general practitioner beds. In particular we were told that mothers preferred to be confined in general practitioner beds as they liked to be attended by their own doctor. There was widespread agreement that more general practitioner beds were desirable. The majority of witnesses thought that the beds should be situated in or near maternity hospitals with consultant advice readily available. Some form of overall supervision was considered necessary but it was thought that the general practitioner should remain clinically responsible for his patients. No definite indication was given of the number of general practitioner beds needed, although one suggestion was that they should account for about half of the total number of maternity beds. A few witnesses thought that there should be a general practitioner wing to every hospital. It was considered that more general practitioner beds would free some hospital beds for ante-natal cases. One witness stated that all available beds would be used but another opinion was that many units had insufficient midwives to staff the beds already available.

252. Many witnesses discussed the question of control of general practitioner beds. We had evidence that where beds were supervised in close liaison with the hospital, and where there was a strict selection of cases, the maternal and peri-natal mortality results were much better than in units which had no supervision. These, in the opinion of one body of witnesses, were potentially dangerous. There was some difference of opinion as to who should exercise the control and what form it should take. Generally, it was felt that a consultant should supervise the unit but one witness thought a general practitioner obstetrician should do so. Another witness considered that the general practitioners and consultants should choose an "administrator" who would normally be the consultant. The control envisaged ranged from friendly supervision to the examination of every case, either to determine admission or as a check at the thirty-second week of pregnancy. Some witnesses suggested that a consultant obstetrician should be in charge of the unit and be responsible for the control of outbreaks of infection.

253. There were some varying opinions on the best siting of the general practitioner maternity beds. One witness wished to see the replacement of maternity homes by beds in maternity hospitals, staffed by general practitioner obstetricians as members of the obstetric team. Some witnesses thought that there should be small local homes, staffed by domiciliary midwives, while others favoured 20 to 30 bedded units on outlying housing estates. It was suggested that in rural areas units should be widely dispersed but that they should be near enough to the maternity hospitals to provide for adequate consultant cover.

254. Most of our witnesses considered that the use of these general practitioner beds should be limited to normal patients, including social cases without medical abnormalities. One witness saw no reason why general practitioners should not deal with abnormal cases. On the other hand another considered that all patients should be seen by a consultant so that only normal cases were admitted. A further witness considered this to be unnecessary as a consultant would always be available.

255. One complaint was received that women were not seen by the midwifery staff at general practitioner units during the ante-natal period, with the result that midwives had to conduct confinements without knowledge of the patients' ante-natal history.

256. Dr. Sluglett and Dr. Walker of Bristol described to us their suggestion for a short stay general practitioner unit attached to a maternity hospital. The unit would consist of a suite of labour rooms to which mothers could be admitted for delivery. As soon as the mothers had recovered from the effects of labour, they would be discharged to their own homes accompanied by a midwife. All care could be provided in the same way as for domiciliary confinements by the general practitioners or general practitioner obstetricians and local authority midwives, the only difference being that labour would take place in the unit and not in the patient's own home. Dr. Sluglett and Dr. Walker considered that their scheme combined the advantages of both a home and a hospital confinement. Deliveries could be conducted under conditions which were safer than at home but at the same time the patients would have their own doctors and midwives to ensure continuity of care. Cross infection among the babies would be reduced.

257. We received no general support from other witnesses for this scheme. It was thought that the administrative difficulties of ensuring that the equipment was properly maintained, the unit kept clean and the catering supervised, would be very great. The rapid succession of patients in a labour ward might result in more, not less, infection. Difficulties might arise where a domiciliary midwife had a number of cases at the same time. The chief objection to the scheme, however, was that patients' homes which were not suitable for the patients' delivery were not suitable for nursing during the puerperium.

Our views

258. We are of the opinion that the extra beds required to enable the hospital confinement rate to be raised to the suggested average of 70 per cent of all confinements, should where possible be general practitioner beds, and where that figure obtains already, some of the existing beds should be made available for general practitioner obstetricians. We consider that all general practitioner obstetricians should have access to general practitioner maternity beds. The number of patients cared for in these beds should count towards the number of cases needed for a doctor's retention on the obstetric list. We consider that general practitioner maternity beds are best situated within, or very close to, consultant maternity hospitals or general hospitals with maternity departments. We recommend that a consultant obstetrician should have overall responsibility for the supervision of the beds, for example, in dealing with outbreaks of infection, while leaving the general practitioner obstetrician clinically responsible for his own patients, yet free to consult the obstetrician of his choice as he thinks necessary. The ideal is mutual respect and willing consultation but some statement of the relative responsibilities of the general practitioner obstetrician and the consultant obstetrician is needed for the guidance of hospitals in making their arrangements, in order to allay any apprehensions about liability in the event of legal action.

259. We recommend that the use of general practitioner maternity beds should be limited to general practitioner obstetricians.

260. We recommend that general practitioner maternity beds should be reserved for normal cases and that patients with known abnormalities should not be admitted to them: if a case becomes abnormal consultant advice should be sought. Patients with unsuitable home conditions may frequently be very suitable for admission to these beds.

261. The responsibility for booking beds at a general practitioner maternity unit should be firmly established. We recommend that a panel should be set up for each unit to deal with all bookings, consisting of the consultant obstetrician, the matron and representatives of the general practitioner obstetricians. The suitability of borderline cases for admission could be decided individually by this panel. The local health authority should be consulted about the patient's home conditions.

CONCLUSIONS AND RECOMMENDATIONS

● After lying-in beds have been allocated to patients in the priority groups, including patients with social needs and those requiring emergency admission, any remaining beds might then be allocated on a "first come, first served" basis. (Paragraph 224.)

- Although it is preferable for a patient to be referred to hospital by her doctor a hospital should be able to book a patient who applies directly to them for admission. (Paragraph 225.)
- An efficient appointment system should be adopted by all ante-natal clinics and prompt measures should be taken to follow up those who fail to attend. Hospitals should endeavour to make every use of both the local health authority staff and general practitioners to carry out this for them. (Paragraph 229.)
- Hospital authorities should provide, as a priority, ante-natal beds for some 20 per cent to 25 per cent of all confinements in the country as a whole. These beds should be reserved solely for ante-natal patients. (Paragraph 231.)
- Maternity hospitals should be organised in self-contained units of such a size that one sister can be in charge of both lying-in and labour wards, and if possible of ante-natal beds as well. (Paragraph 233.)
- Every attention should be paid in hospital to the mental and physical care and well-being of women during pregnancy and childbirth. (Paragraph 234.)
- Premature baby units with adequate space and sufficient in number to cover the whole country should be provided. (Paragraph 238.)
- There should be sufficient "flying squads" to cover the country as a whole; they should be properly staffed; and adequate transport should be available. Equipment for resuscitation should be kept in local hospitals and should be available to general practitioner obstetricians pending the arrival of the flying squad. (Paragraph 245.)
- Local health authorities and general practitioner obstetricians should do all they can to co-operate with teaching hospitals in maintaining and extending facilities for training medical students in domiciliary midwifery. (Paragraph 247.)
- The extra lying-in beds required to enable the hospital confinement rate to be raised to the suggested average of 70 per cent of all confinements should, where possible, be general practitioner beds. (Paragraph 258.)
- General practitioner maternity beds are best situated within, or very close to, consultant maternity hospitals or general hospitals with maternity departments. A consultant obstetrician should have overall responsibility for supervision of general practitioner maternity beds. (Paragraph 258.)
- All general practitioner obstetricians should have access to general practitioner maternity beds. (Paragraph 258.)
- The use of general practitioner maternity beds should be limited to general practitioner obstetricians. (Paragraph 259.)
- General practitioner maternity beds should be reserved for normal cases. (Paragraph 260.)
- A representative panel should be set up for each general practitioner maternity unit to deal with all bookings. (Paragraph 261.)

CHAPTER 10

A COMBINED OR SEPARATE MATERNITY SERVICE?

262. Of the witnesses who gave evidence to us one-third made no mention of the administrative arrangements of the maternity service and we presumed that they were content that the existing system should continue. Of those who made comments upon the present arrangements, about three-fifths were content with the tripartite structure, which they considered worked reasonably well or could be improved by minor adjustments, and the remainder proposed definite administrative changes.

The evidence we received

263. While many witnesses complained of a lack of co-ordination in the present tripartite administration the majority did not explain what they meant by co-ordination or where they considered it was needed. The remainder, however, said that the present administration resulted in overlapping or gaps in the service and in rivalry between the members. Some witnesses thought that when a mother was cared for under more than one branch of the service overlapping was inevitable. These witnesses pointed out that the "Report on Confidential Enquiries into Maternal Deaths in England and Wales 1952-1954" showed that an improvement in the general standard of ante-natal care was the essential factor if any reduction in maternal mortality or morbidity was to be secured. They contended that with ante-natal care being provided by the three unco-ordinated branches of the service not only was overlapping inevitable but many women failed to receive the care to which they were entitled. They alleged that an expectant mother might attend a local authority clinic to book a midwife who might examine her, possibly with the local authority medical officer. The mother would then be advised to see her own doctor who either examined her himself or sent her to a general practitioner obstetrician who would do so. At any stage she might be referred to a hospital ante-natal clinic where she might again be examined. If she was booked for home confinement, she would periodically be examined by a doctor and a midwife and possibly by the local authority medical officer as well. These examinations might be spaced throughout pregnancy but might sometimes occur within a few days of each other followed by a long period without attention. The same multiplicity of attendants which caused overlapping of medical attention, might, from lack of co-operation, equally well result in omissions in the care of the mother when each attendant was under the misapprehension that the other was carrying out the work. Thus a mother booked for domiciliary confinement might receive little or no ante-natal care because the midwife was under the impression that the patient was attending the doctor and receiving all care from him, while the doctor assumed that the mother was attending the local authority clinic and was receiving ante-natal care from the local authority medical officer and the midwife. Neither might

be sure, nor take steps to ascertain, whether the other had arranged for blood and other tests. Neither might be sure, nor take steps to ascertain, whether the midwife was acting in her capacity as a midwife carrying out full ante-natal care and conducting the delivery, or as a maternity nurse, that is, only assisting the doctor at the confinement. As a result, neither might take the responsibility of seeing that treatment of any abnormality was undertaken as soon as any deviation from the normal occurred. Similarly, an expectant mother sent by her family doctor for hospital confinement, might be assumed by him to be receiving full ante-natal care from the hospital. If, however, she failed to attend the hospital ante-natal clinic, the hospital might assume without making further inquiries, that she was receiving care elsewhere.

264. Evidence was given of other examples of omission in ante-natal care caused by administrative confusion. For instance, hospitals and general practitioners seldom arranged for their patients to receive health education or ante-natal exercises unless they themselves provided special classes. It was stated that matrons of general practitioner units were often unaware of the result of the ante-natal care of patients admitted in labour when the general practitioner had carried out the examinations himself. On the other hand one witness considered that while in theory a patient might fail to get adequate care because each authority assumed the other was providing it, in practice this seldom occurred.

265. Several witnesses spoke of rivalry between members of the service, mentioning the midwife's fear of "losing" a case to a general practitioner. They spoke of the feeling of a general practitioner that, if he allowed his patient to attend the local authority clinic for care (including health education), she might not return to him or that if he referred his patient to a hospital for consultation the hospital would "take" the case and book her for hospital confinement.

266. Many witnesses complained of the lack of "continuity of care" of the patient. The phrase, however, appeared to be used with a variety of meanings. In the main it was interpreted as meaning that one person should provide a woman with the whole of her maternity care. Others considered that as childbirth was a normal, although important, incident in a woman's life "continuity" should imply that her maternity care should be given, as part of her ordinary medical attention, by her family doctor. Others thought that continuity of care meant care not by one person but by a number of persons each having well defined functions and working in close association. They stressed that it was important that the patient should be aware of this co-operation.

267. A few witnesses stated that there was no single authority to ensure that the care provided by each agency was up to standard. They stated that the midwife was closely controlled by the local supervising authority and the hospital staff by the consultant but the only requirement of the general practitioner was to provide the minimum care necessary to qualify for his fees from the Executive Council.

268. The tripartite structure was also said to result in an uneven provision of services but in the main this criticism applied only to the availability of hospital beds which was already subject to regional planning by Regional

Hospital Boards. Other witnesses complained that while the boundaries of the local health authority and the Executive Council were defined and corresponded with each other, there was no definite hospital catchment area. A hospital might take patients from the areas of several local health authorities and Executive Councils. Similarly a doctor might work in one or more local Executive Council areas. These witnesses felt that there should be one single authority responsible for seeing that every woman received adequate ante-natal care whether by the general practitioner obstetrician in his surgery, or in hospital, or in a local authority clinic. Some of these thought that this could be secured by co-ordination and by advisory committees: the majority, however, felt that the best method was to have one single body responsible for the whole of the maternity services.

269. On analysis of the evidence three points emerged. Firstly, the general practitioner and the domiciliary midwife were not always clear as to what their respective functions were and each did not always know what ante-natal care the other was providing and which of them was to conduct the delivery. Secondly, a general practitioner did not always know when a patient of his was booked for hospital confinement. He was not always kept informed of her progress yet he might be called to her home in an emergency or be asked to provide her with interim ante-natal care. If she were admitted to hospital he would not know what care she needed after her discharge. Thirdly, the patient sometimes received conflicting advice.

SUGGESTED CHANGES IN THE ADMINISTRATIVE STRUCTURE

270. Many different systems of administration, covering practically every possible variation, were proposed by those witnesses who thought that some change was needed. The majority of witnesses also gave reasons why they were opposed to any particular change. An attempt is made here to summarise the various opinions offered to us.

271. Some witnesses suggested that all confinements should take place in hospital, a suggestion that, if it were adopted, would end the present tripartite structure of the maternity service. As this has been elaborated in Chapter 5, only brief mention will be made of it here. It was not advocated by anyone as an immediate solution but some of our witnesses thought it a desirable objective. Most arguments we received were, however, against this proposal. Some witnesses thought it could not be justified on either medical or social grounds while others spoke of the prohibitive capital cost unless the length of stay in hospital was reduced. The lack of hospital midwives to staff such a service and the possibility that domiciliary midwives might refuse to work in hospitals, were mentioned. Other witnesses said that it would mean that in remote areas there would be an increased risk of delivery in ambulances. The chief criticism of the proposal that all confinements should take place in hospital was, however, that some mothers preferred to have their babies at home. Both domiciliary and hospital maternity services should therefore be provided.

272. Six possible forms of administration were suggested as follows:—

- (a) a new single authority;
- (b) a single service administered by the local health authorities;
- (c) a single service administered by the hospital authorities;

- (d) a bipartite structure with the local health authorities administering domiciliary midwives and maternity hospitals with the Executive Councils administering maternity medical services;
- (e) a bipartite structure with the local health authorities administering domiciliary midwives and maternity medical services with the hospitals remaining under the existing hospital authorities;
- (f) a bipartite structure with the existing hospital authorities administering the hospitals and domiciliary midwives with the Executive Councils administering maternity medical services.

(a) *A new single authority*

273. Very few witnesses favoured a new single authority to administer the midwifery services and in the main it was presented as a fourth body to co-ordinate and control the work of the existing three services. One witness proposed that a Maternity Services Board should be set up under the Ministry of Health. It should consist of representatives of the Regional Hospital Boards, of the governing bodies of the teaching hospitals, of local health authorities, of the Royal College of Obstetricians and Gynaecologists, of the British Paediatric Association, of the Royal College of Midwives and of the mothers. The Board should have executive powers to direct and re-organise all branches of the service in co-operation with the local authorities, hospitals and professional bodies.

274. The disadvantages of such a system were mentioned by some of our witnesses who considered it would not be possible to set up a new single authority for midwifery when all the remaining services continued to be administered under a tripartite system. They stressed the difficulty of running a general hospital with a maternity department when one part of the hospital remained under the present system and another part was administered by a new body. Other of our witnesses were of the opinion that if the members of separate services were not prepared to collaborate, it would be doubtful if a new single authority could achieve co-operation, for in their opinion, co-operation had not invariably been secured when both maternity hospitals and domiciliary midwifery had been under the control of the local authorities.

(b) *A single service administered by the local health authorities*

275. Very little evidence was given in favour of this system. One witness suggested that the tripartite structure caused confusion and that the "maternity services should be the responsibility of the local health authority and that the Medical Officer of Health would wholly administer the domiciliary services". A few witnesses stated that they would have liked this system of administration but did not think it practicable. The chief argument against this proposal was the difficulty of transferring the maternity department of a general hospital to the local health authority and the further difficulty of obstetricians working under local health authorities but remaining, as gynaecologists, employed by the hospital authorities.

(c) *A single service administered by the hospital authorities*

276. The majority of those of our witnesses who advocated a change seemed to favour a single service administered by the hospital authorities. Some considered that it should be introduced immediately, while others

thought that if the hospital confinement rate rose to such an extent that the domiciliary service became uneconomical, the hospital authorities should administer the whole service, at least in urban areas, where the midwives were not also district nurses.

277. Generally the type of scheme favoured was that put forward by the Royal College of Obstetricians and Gynaecologists. This would consist of a central control by a Standing Obstetric Advisory Committee of the Central Health Services Council composed of six obstetricians, three general practitioner obstetricians, two Medical Officers of Health, four midwives, two lay persons, one paediatrician and three senior administrative medical officers. Each Regional Hospital Board area would have a joint Regional Obstetric Committee with executive powers delegated to it by Regional Hospital Boards and Boards of Governors to "organise, co-ordinate and keep under constant review the obstetric service of the area". An annual report would be sent by each regional committee to a Standing Obstetric Advisory Committee which would then be in a position to review regional and national results and would advise the regional committees on policy. Recommendations would be sent to the regional committee by the Area Advisory Obstetric Committees whose function would be to co-ordinate the services locally. They would be set up by each Hospital Management Committee with a major obstetric unit. The first duty of the joint Regional Obstetric Committees would be to work out "obstetric areas" each centred on a maternity hospital or maternity unit of a general hospital. They would also be responsible for maintaining the obstetric list. The general practitioner obstetricians and midwives at present normally practising in these areas would together with the consultants from the hospital become part of the team for the area. These "obstetric areas" were not envisaged as having restricted boundaries so that ambulances conveying special cases or the "flying squad" could pass freely beyond them.

278. The advantages of this or of a similar scheme were outlined by many witnesses. They considered that a unified service was in principle better than a tripartite structure and as the hospitals undertook the majority of midwifery in this country, the hospitals should control the service. It was contended that under single control it would be easier to ensure a proper selection of cases for home and hospital confinement. In view of the present shortage of midwives, a more economical use could be made of them if they were controlled by one authority. The early discharge of patients from hospital could be facilitated. The present duplication of local authority and hospital services could be overcome, although the hospitals would probably need to use the local authority premises for outlying ante-natal clinics. Better teaching facilities would then be made available for pupil midwives and medical students which in turn could lead to better trained midwives and doctors.

279. We had equally strong evidence against the proposal by witnesses who considered that the hospitals had neither the staff nor the administrative experience to control a service outside the hospital. They considered that there was an essential difference of outlook between the running of a hospital and a domiciliary service, in that the hospital was not "preventive minded". This difference had been present even when the local authorities were

running both services. Midwifery in the home was stated to be the function of the general practitioner so that if he was under contract to the hospital for maternity care, his midwifery would be divorced from his other work. There were already many vacancies for midwives in maternity hospitals and it was stated that domiciliary midwives would not be willing to take hospital posts. The difficulty of administering a midwifery service in rural areas where the midwife combined all home nursing duties was pointed out and it was suggested that a change of system of this kind might lead to a serious breakdown in the nursing services. Finally the lack of defined hospital areas was stressed.

- (d) *A bipartite structure with the local health authorities administering domiciliary midwives and maternity hospitals with the Executive Councils administering maternity medical services*

280. The suggestion was put forward by a few witnesses who considered that maternity hospitals and maternity departments of general hospitals should be returned to the local health authorities. In their opinion the accent should be on normal confinement in the home as childbirth was not an illness. They considered that the local health authorities were the only bodies equipped to deal with maternity care in all its aspects having had long experience of home conditions, family welfare and all other aspects of childbearing. Maternity hospitals on the other hand looked after patients only for a short period. While a few witnesses favoured this scheme, most of them considered it impracticable to transfer part of a hospital to another authority.

- (e) *A bipartite structure with the hospital authority administering maternity hospitals with local health authorities administering both domiciliary midwives and maternity medical services*

281. A few witnesses suggested that the hospital services should remain as at present but that general practitioners should be under contract to the local health authorities to provide maternity medical care in their own surgeries, in the patients' homes, or in ante-natal clinics. It was suggested that a domiciliary obstetric committee should be set up by the local health authority, with adequate representation by general practitioner obstetricians, to be responsible for the day-to-day running of the service.

282. Other witnesses were opposed to this scheme, however, on the grounds that it would cause administrative problems, for example, in disciplinary matters if the doctors were under contract to two authorities. It was also stated that general practitioners would be unwilling to work under the local health authorities.

- (f) *A bipartite structure with the hospital authorities administering maternity hospitals and the domiciliary midwifery services with the Executive Councils administering maternity medical services*

283. A number of our witnesses was in favour of transferring the domiciliary midwives to the hospital, for they considered that this would be more economical in both money and midwifery staff. They thought that a unification of the control of the midwives would result in a better liaison between the hospital and the domiciliary services, so ensuring continuity of care of the patient and a higher standard of midwifery. They also suggested that there

would be more control by the teaching hospitals so that better facilities would be available for the teaching of medical students. Some witnesses thought that if the hospital confinement rate became very high it would become necessary to transfer the responsibility for the domiciliary midwifery service to the hospitals. The Teaching Hospitals Association and one Hospital Management Committee based their evidence on practical experience of running such a service. Under the arrangements described by the Hospital Management Committee the hospital matron assisted by a sister-superintendent was responsible for the domiciliary services. Following a letter from the general practitioner, social cases were reviewed by a local authority health visitor and a hospital midwife before a patient was booked. Ante-natal care and post-natal care were carried out by the midwife and the general practitioner but specialist cover was available as necessary. If the midwife needed medical aid and the general practitioner was not readily available she applied directly to the hospital. Periodical reports of the work done were sent to the Medical Officers of Health and to a joint sub-committee. The service was run quite separately from the in-patient maternity department.

284. Several witnesses were against this scheme. They considered it was important to retain all the domiciliary services under one authority especially in rural areas where the midwives had combined duties. It was thought that while more efficient use might be made of the midwifery staff if they worked under one authority, many domiciliary midwives would be unwilling to work for a hospital and might resign. Under the proposed system unity could not be achieved because doctors would still be working under a different branch of the service and the lack of defined hospital areas for domiciliary and institutional confinements would make administration difficult.

SUGGESTED IMPROVEMENTS OF THE PRESENT TRIPARTITE STRUCTURE

285. As already stated, the majority of our witnesses who mentioned the administration of the service, considered that the present system worked well or could be made to work well with various alterations. A number said that any radical change in the present administration might cause more dislocation and confusion than it removed. Most of these witnesses considered that there was no evidence that confusion need or generally did occur as a direct result of the tripartite structure. One authority said that they had no evidence that the present tripartite arrangements were fundamentally wrong and thought that while unification might achieve administrative tidiness, it did not follow that good obstetrics were dependent upon scrupulously streamlined administration.

286. Most of the suggestions were for some form of co-ordination either by committees or by individuals. Several witnesses wanted co-ordinating committees although some did not specify the type of committee. Some wanted regional and local co-ordinating committees with the hospitals as the senior partners. Others wanted clinical advisory committees for defined hospital areas with the hospital consultant responsible for the local authority and hospital ante-natal clinics, and the general practitioner obstetrician providing interim ante-natal care. Other methods of co-ordination by individuals were suggested. Some witnesses wanted the general practitioner

or general practitioner obstetrician to act as co-ordinator. It was thought general practitioners should have access to more hospital beds and that thereby the standard of care and co-operation might be improved. Other witnesses considered that there should be more clinical assistantships for general practitioners and for local authority doctors. More use of the local health authority clinics by hospital consultants was urged by some witnesses. Others thought that every pregnant woman should attend hospital for her first examination. Each hospital could then keep a central record of maternity cases.

287. A number of witnesses, while wishing to retain the present structure, considered that there was no longer a need for the local health authority medical officer in the ante-natal clinic, as he duplicated the work of the general practitioner obstetrician. This has already been discussed in paragraph 147.

OUR VIEWS ON THE FUTURE ADMINISTRATION OF THE MATERNITY SERVICE

288. After long and careful consideration of the administration of the maternity services, we have come to the conclusion that at present the tripartite structure should be retained. We consider that neither the Executive Councils nor the local health authorities could provide a unified service or administer the maternity department of a general hospital while all the other departments of the hospital remain under the control of the present hospital authorities. Further we rejected the proposal that there should be an ad hoc committee to administer the maternity services. We are convinced that the general practitioner obstetrician should become more closely linked with the hospitals and we therefore decided against recommending the transfer of maternity medical services to the local health authorities. Thus we were left with two possible alternatives: either there should be a unified service under the control of the hospital authorities, or the present tripartite system, with certain modifications, should continue.

289. The majority of us are agreed that if the personal health services, closely associated as they are with the general practitioners and the hospitals, could be planned entirely anew, administration by a single authority for each area would be preferable to administration through three functional branches as at present. There is, however, always a possibility that a single authority centrally financed might lead to overcentralisation and rigidity resulting in a lack of local initiative. Moreover, at present local authorities can use their local revenue on projects for which Exchequer finance is not forthcoming. Furthermore, the block grant system established by the Local Government Act, 1958, is expressly designed to encourage local initiative.

290. In considering the unification of the maternity services under the hospital authorities we recognised that it would have many advantages. The country might be divided into maternity districts, each being based on a Hospital Management Committee with a sizeable maternity unit. The general practitioner obstetricians could be in contract with and domiciliary midwives employed by the Hospital Management Committee. Medical control could be exercised by the hospital consultant obstetricians. The duties of the local supervising authorities could be transferred to hospitals. It might be

possible to employ midwives more economically as between a hospital and a district because being financially responsible for both services, a single authority would be able to estimate the proportion of hospital and domiciliary confinements quite objectively and to make provision for them. At present there are no defined hospital areas and a general practitioner has a wide choice in deciding which is the most suitable hospital for his patient. While the definition of hospital maternity districts would result in a restricted area for the domiciliary midwifery service, it would not of necessity restrict this choice. In so far as certain hospitals provided special facilities as for example, premature baby units, no new problems of co-operation would be likely to arise. The present distribution of hospitals is very uneven so that while a county borough may have two or more hospitals in a small area, in some rural counties the distance between consultant centres may be anything up to 60 miles but even so an area covered by a maternity district would be no larger than many counties.

291. A major disadvantage of this system, however, is that in country districts where there is often insufficient work for whole-time midwives or whole-time district nurses, the midwives may be home nurses and health visitors. The proportion of their time which is devoted to midwifery tends in small districts to vary considerably according to the number and frequency of births and this might raise new administrative problems. In our view the fundamental difficulty is that the domiciliary midwife is a member of two separate teams which between them deal with the mother throughout her life in which childbirth is an incident although an important one. On the one hand the midwife must work in close co-operation with the general practitioner obstetrician and the maternity hospital, and on the other with all the officers of the domiciliary services provided by the local health authority—health visitor, welfare officer, psychiatric social worker and home help, who must themselves work in co-operation with the general practitioner and the general or specialist hospitals. That in country districts a midwife may also be a home nurse, health visitor or school nurse only stresses her importance as a member of the domiciliary team.

292. It may well be true that the maternity service would be strengthened if the hospital staff, the general practitioner obstetrician and the domiciliary midwife were all employed by the same body and that body were responsible for all the services given to the expectant and nursing mother but much the same is true of all the other branches of the National Health Service.

293. We have finally come to the conclusion that at present the tripartite structure of the maternity service should be retained as it is not practicable to transfer the maternity services alone to hospital control when all other health services remain under the tripartite structure. While it seems reasonable to suppose that there would be less room for failure of co-operation if all the services were administered by one body instead of three, we have received evidence by some local authority witnesses that when they controlled both hospital and domiciliary maternity services prior to 1948, co-operation had not always been more successful than now.

294. To an ever increasing extent the modern practice of medicine has turned towards preventive work, early diagnosis and early treatment both for patients living at home as well as for those in hospital. Larger out-patient

clinics, more domiciliary consultations and the provision of mass radiography units show how the hospital service is turning that way. In fact the institutional and domiciliary care provided by hospitals and local health authorities are complementary. Old persons and mental patients for example can often be discharged from hospital to their homes and to the care of the doctor and the local authority domiciliary team, perhaps to return later for more in-patient treatment to enable them once more to go home when their condition is again relieved.

295. In these circumstances there are the same risks of overlapping and of the patient falling between the two stools of two unco-ordinated services as there are in the present maternity service of which we have heard so much in evidence. We have thought that it went beyond our terms of reference to consider the relations between the whole of the institutional care provided by the hospital and the whole of the institutional and domiciliary care provided by the local health authorities and as we have said elsewhere we do not feel that it is possible to deal with the maternity services in isolation.

296. We took note of the recommendations of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 who faced with a similar situation decided that the treatment of mental illness could not be divorced from the administration of the health services generally. We also took note of the recommendation of the Guillebaud Committee in 1956 that the administration of the National Health Service should remain unchanged and found that difficult to reconcile with the subsequent provisions of the Local Government Act, 1958, which provide for the delegation of local health and welfare functions to smaller local authorities. We remembered, however, that that Committee was appointed to enquire into the cost of the National Health Service.

297. While integration is a desirable aim the National Health Service is as yet young and as experience accumulates it might develop towards a unified service in ways which cannot be foreseen at present. We consider, however, that the spontaneous co-operation here and there on the part of those engaged in the health services has already brought the three branches closer together and might well pioneer the natural evolution of a unified service.

298. We consider that with a tripartite service, co-ordination is required at the administrative and executive levels. The first, at administrative level, to ensure that three independent comprehensive services are not built up and to see that each part knows its own sphere so that no particular function is left neglected. The second, at executive level, to ensure that each member is aware of his duties and that they interlock with those of the other members. As has been shown, most of the complaints appear to be due to lack of co-ordination between the officers and might well occur whether the service was unified or in two or three sections.

299. In order to better the present administration, measures need to be taken to improve the co-operation and co-ordination of the three branches of the service. Some interchange of domiciliary and hospital staff would be desirable, if the practical difficulties could be overcome, particularly where the proportion of domiciliary confinements is below 30 per cent or the actual number of deliveries is small. We wish to emphasise our view that there

should be a firm link between the general practitioner obstetrician and the hospital so that he becomes part of the obstetric team. In our view the financial arrangements for payment for maternity medical services should be made in such a way as to encourage this co-operation and we recommend that a method of doing this would be for the general practitioner obstetrician to be remunerated for maternity medical services by the hospital authorities. If this system were adopted it would also simplify the checking of doctors' claims to which we refer in paragraph 204.

300. Under the provisions of the Local Government Act, 1958, for the delegation of health service functions to district councils it will be important that the new authorities, through their officers, maintain a close contact with the officers of the Hospital Management Committees. It may be that if the number of domiciliary births in their areas is insufficient to maintain an economical domiciliary midwifery service, these new authorities might consider making arrangements for this service to be provided by the local Hospital Management Committees. It may be that the provisions of the National Health Service Act, 1946, are wide enough to enable this to be done: if they are not we suggest that amending legislation should be considered.

CONCLUSIONS AND RECOMMENDATIONS

- At present the tripartite structure of the maternity service should be retained as it would not be practicable to transfer the maternity service alone to hospital control when all other health services remain under the tripartite structure. (Paragraph 293.)

- Measures need to be taken to improve the co-ordination and the co-operation between the three branches of the maternity service. (Paragraph 299.)

- There should be a firm link between the general practitioner obstetrician and the hospital. To strengthen this link fees for maternity medical services should be paid to general practitioner obstetricians by the hospital authorities. (Paragraph 299.)

- Those local authorities, to whom health service functions are delegated under the provisions of the Local Government Act, 1958, who find it difficult because of the small number of domiciliary confinements to maintain an economical domiciliary midwifery service, might make arrangements for this service to be provided by the local Hospital Management Committees. (Paragraph 300.)

CHAPTER 11

CO-ORDINATION ARRANGEMENTS

SUGGESTIONS FOR CO-ORDINATION

The evidence we received

301. There was general agreement among our witnesses that if the present tripartite structure of the maternity service were to remain then better methods of co-ordination and co-operation were needed. We received many and divergent opinions on how this could be achieved.

302. Many of our witnesses were in favour of co-ordinating committees. One witness envisaged that the hospitals should become senior partners in regional and local co-ordinating committees, co-ordinating but not running the domiciliary midwifery services. Another witness suggested that hospital areas should be defined, each with a clinical advisory committee, the hospitals staffing the local authority clinics and the general practitioners providing interim ante-natal care for all expectant mothers.

303. Another method which was favoured by many witnesses was the introduction of co-operation cards on which the essential details of the patient's ante-natal care were recorded. Generally a standard card for the country was favoured except by one witness who thought that the form and content were matters for local arrangement in the light of local circumstances. Most witnesses considered that a co-operation card would prevent duplication of examination while one thought it would be of great value to relief midwives attending patients in labour. Various suggestions were made concerning the type of card. One witness thought it should be single, strong and of a size which would fit into a general practitioner's record envelope but other witnesses favoured cards in duplicate or triplicate. Some witnesses considered the card should contain a complete record of the patient's care while others thought that it should be subsidiary to a main card, suggesting that there should be a recognised symbol to indicate that more information was available. Some witnesses favoured a sealed envelope for the card but others thought it should be open. Opposing views were expressed as to whether the patient should carry the co-operation card or not. Many suggestions were made as to what information should be recorded on the card and they included the following:— doctor's and midwife's names and addresses; midwife's telephone number; A.B.O. and Rh. blood grouping; family history including the occurrence of multiple pregnancies; weight; blood pressure readings and the result of urine tests.

304. Various other methods of co-ordination were suggested but few received as much support as co-ordinating committees and co-operation cards. One witness said that ante-natal care was a preventive matter which called for an organisation for the registration of patients, checking up of attendance at clinics, follow-up of non-attenders and the compilation of records. One witness suggested that a central record should be kept from

which information could be obtained by telephone. Another thought that every pregnant woman should attend the hospital for a first consultant visit and that the hospital would then keep a central list of patients' names.

305. The need for co-operation between individual members of the service was stressed by many witnesses. This has already been referred to in the preceding chapters of our Report, so that only special points will be mentioned here. Evidence was given of the need to define the responsibilities of each body clearly to prevent gaps and overlapping in the service.

306. Some witnesses considered that the general practitioner should be made the co-ordinating agent, planning the pattern of care for each patient and referring her to the hospital when he thought it advisable. Various suggestions were made for improving the co-operation between the hospital and the general practitioner. Some witnesses thought that increased access to hospital beds would improve the standard of general practitioner care and would also increase the co-operation between the general practitioners and the hospital staff. One witness suggested that ward rounds should be made compulsory for general practitioners.

307. One group of witnesses considered that co-ordination between the midwives and the general practitioners could be improved by limiting the number of general practitioner obstetricians, so that midwives would be able to attend the doctors' surgeries with the patients. Consultation between the midwife and the doctor when the patient was 36 weeks pregnant, so that it could be decided who would undertake the delivery, was also suggested. Witnesses considered that the midwife should telephone the doctor when the patient went into labour.

308. Some methods of improving co-operation between the local health authority clinics and the hospitals were put forward. One witness suggested that local authority medical officers should hold clinical assistantships in the maternity hospitals. Another witness suggested that each local authority clinic should be affiliated with a maternity hospital and that the hospital obstetrician should hold consultant clinics in local authority premises.

Our views

309. As we have indicated throughout our Report we consider that there is a need for a greater degree of planned co-ordination of the activities of all the persons carrying out maternity care. We do not, however, believe that a rigid pattern of co-ordination can or should be laid down for the country as a whole because circumstances vary in different areas and may call for the special co-ordination machinery most suited to the needs of the particular locality. However, there is a certain general pattern of local co-ordination which we think could be adapted to local needs.

LOCAL MATERNITY LIAISON COMMITTEES

310. We consider that in order to effect the co-ordination of the administrative arrangements of the maternity service provided by the three branches of the health service, local maternity liaison committees, with a professional membership, should be set up, whose task it would be to ensure that the local provisions for maternity care in the area, whether provided by the hospitals, the local health authority or the general practitioner obstetrician were used to

the best advantage. This task would include making local arrangements to ensure that there was a proper selection of patients for hospital confinement, that a sufficient number of hospital beds was reserved for ante-natal care and that there was no over-booking. The Committee would have to ensure that there was the closest co-operation between the hospital and the local health authority as the latter would be responsible for assessing cases of social need and for providing health education both for patients booked for hospital confinement and for those booked under maternity medical services by general practitioner obstetricians. The liaison committee would have to make sure that the hospital and specialist services were available when necessary to general practitioner obstetricians.

311. We envisage that these Committees would ordinarily be organised at Hospital Management Committee level and would cover either one individual hospital with a sizeable maternity unit or several hospitals within a well defined area. Differing local circumstances may give rise to a diversity of arrangements. We consider, however, that in all areas these Committees should consist not of lay members but of persons working in the maternity services in the area, such as consultant obstetricians, domiciliary and hospital midwives, medical staff of the local health authority and general practitioner obstetricians. Where more than one hospital or local authority is concerned each will need to send representatives to the Committee. We suggest that machinery somewhat akin to that set up to consider the memorandum on "Ante-natal Care Related to Toxaemia", in which the initial responsibility of convening the meeting of those authorities concerned was placed upon the Chairman of the Hospital Management Committee, might be appropriate for the local maternity liaison committees. (See Appendix II.)

LOCAL CLINICAL MEETINGS

312. The British Medical Association and the Society of Medical Officers of Health among others suggested that there should be opportunities for general practitioners undertaking maternity medical services to discuss the clinical aspect of cases. The British Medical Association, however, thought that general practitioners might find it difficult to spare the time for such contacts and suggested that evening or Sunday morning talks might be arranged.

313. It was also suggested to us that the publication by hospitals of clinical reports was very useful. It was said that some hospitals had discontinued their practice of publishing these reports because of the expense involved and it was suggested that, as an economy measure, Regional Hospital Boards could produce and publish summaries of these clinical reports but that the full report should be available for those interested.

314. We ourselves are very much in favour of clinical meetings which could bring together for discussion of clinical cases all those persons responsible in a particular area for carrying out maternity care. We envisage the meetings being held in each maternity hospital at not too infrequent intervals, convened probably by the consultant obstetrician and attended by at least the consultant obstetrician, a medical representative of the Medical Officer of Health of the area, and any local general practitioner obstetricians who could attend. We consider that the consultant obstetricians are the appropriate persons to take the initiative in calling these meetings.

315. We consider that the publication by the hospitals of clinical reports should, despite the cost, be encouraged and extended with the co-operation of the local authority to cover the domiciliary midwifery service in the area. This would, in our opinion, be a fruitful field for local co-operation between the branches of the maternity service.

STANDARD CO-OPERATION CARDS

316. We are in favour of the introduction of a standard co-operation card for use on a national basis. We believe that if such a card were provided for every woman receiving maternity care this simple procedure alone would go a long way towards eliminating some of the present lack or duplication of care. We understand that the Standing Maternity and Midwifery Advisory Committee are at present considering the design and content of a standard co-operation card and we are content to leave the details to them. We are inclined to favour the proposal that the card should be kept by the mother and that it should be issued by whoever first undertakes to provide maternity care. It is clearly important that all the persons participating in the provision of maternity care should complete their entry on the card as fully as necessary to ensure that each member of the obstetric team is aware of the attention given by the other members.

CO-ORDINATION OF MATERNITY CARE

317. We have already discussed in other chapters of our Report the methods by which the co-ordination of maternity care might be developed. It is important that each individual should be aware of his responsibilities. We have suggested that hospitals or general practitioner obstetricians, whichever undertake the patients' maternity care in the first instance, should be responsible for ensuring that it is carried out without duplication or omission either by themselves or by the persons to whom they delegate. This responsibility should include ensuring that adequate health education is given. As we have already indicated hospitals should pay particular attention to this.

318. It is important that general practitioner obstetricians should strengthen their co-operation with the midwives who jointly with them undertake the maternity care of patients booked for home confinement, so as to ensure that a programme of maternity care is arranged and allocated between doctor and midwife as soon as possible after pregnancy has been confirmed. Where possible both the doctor and the midwife should be present at the examination of the expectant mother.

SUGGESTED PROCEDURE FOR THE EXCHANGE OF INFORMATION

319. We consider that a proper system for the exchange of information between the various professional officers in charge of a patient would do much to ensure a better integration of the maternity service. In Appendix VIII we have indicated arrangements which we consider should be adopted. All such exchange of information would of course be with the patient's consent.

320. It is probable that a woman would first attend her family doctor for confirmation of her pregnancy and he should then ensure that she either attends at hospital or books a general practitioner obstetrician and midwife. Should any infectious disease occur in the patient's family during her pregnancy he should inform either the hospital or her general practitioner obstetrician. The family doctor may be asked to follow up patients who fail to attend for ante-natal care and we wish to stress that we feel that such visits should be paid as soon as possible. It may be convenient for him to enlist the assistance of the health visitor or the midwife for this purpose.

321. A hospital should refer all women seeking admission on social grounds to the local health authority for written assessment of their home conditions. When a patient is booked for hospital confinement her family doctor and also the local health authority should be informed if the hospital does not itself provide health education. If interim ante-natal care is to be provided by the local health authority or by the general practitioner obstetrician, the co-operation card should be filled in and should indicate when the patient should attend the hospital again. If ante-natal care is provided by the hospital and any abnormality arises during pregnancy the patient's family doctor should be informed so that he will be aware of her condition should he be called to see her in an emergency. If a patient fails to attend hospital for ante-natal care her family doctor or the officers of the local health authority should be asked to call upon her. The family doctor and local health authority should be informed of the patient's discharge, it being particularly important that this information should be given in advance if the mother is to be discharged early.

322. If the patient is under the care of a general practitioner obstetrician he should inform her family doctor that he has booked her for confinement, of any abnormalities which arise and if she is admitted to hospital in an emergency. He should ensure that she books a midwife and that she receives any necessary health education. Either he or the midwife should fill in a co-operation card to make certain that the patient receives all necessary ante-natal care and that duplication of examinations is avoided. When he discharges the patient from his care, he should inform the family doctor. A similar system for the transfer of information will also be needed if the patient is booked for a general practitioner unit as the staff of the unit will wish to know the patient's ante-natal history when she is admitted for her confinement. The unit should notify the general practitioner obstetrician when they book his patient and should fill in the co-operation card, if they themselves provide any of the ante-natal care.

323. The domiciliary midwife for her part should always ensure that her patient books a doctor for home confinement. She should see that the patient attends regularly for ante-natal examinations. The midwife should fill in the co-operation card and should encourage her patient to attend classes for health education.

324. The local health authority should be responsible for giving reasons in writing to the hospital for the admission of patients for social reasons. They should follow-up "defaulters" from hospital clinics when requested and ensure that a health visitor or a midwife attends the patient after she is discharged from hospital.

CONCLUSIONS AND RECOMMENDATIONS

- Local maternity liaison committees with a professional membership should be formed to ensure that local provisions for maternity care are utilised to the best advantage. (Paragraphs 310 and 311.)

- Local clinical meetings should be encouraged so that all persons in an area responsible for carrying out maternity care can discuss the clinical aspects of maternity cases. (Paragraph 314.)

- The publication of clinical reports by the hospital authorities should be encouraged and extended with the co-operation of the local authorities to cover the domiciliary midwifery service. (Paragraph 315.)

- A standard co-operation card should be provided for use on a national basis. (Paragraph 316.)

- Arrangements for the exchange of information between the various individuals carrying out maternity care need to be strengthened and we have indicated in paragraphs 319 to 324 and in Appendix VIII arrangements which should be adopted. (Paragraphs 319 to 324.)

CHAPTER 12

SUMMARY OF OUR CONCLUSIONS AND RECOMMENDATIONS

CHAPTER 5. THE PLACE OF CONFINEMENT: HOME OR HOSPITAL?

325. The hospital maternity service should be expanded and a good domiciliary maternity service should continue to be maintained. (Paragraph 60.)

326. A more uniformly high standard of ante-natal care is essential. (Paragraph 60.)

327. A more careful selection of patients should be made for domiciliary confinements and for admission to hospital. (Paragraph 60.)

328. The local health authority is the appropriate authority to determine whether social reasons make a home confinement undesirable and they should always be consulted by hospital authorities before a decision is made to book a patient solely on social grounds. (Paragraph 69.)

329. Sufficient hospital maternity beds to provide for a national average of 70 per cent of all confinements to take place in hospital should be adequate to meet the needs of all women in whose case the balance of advantage appears to favour confinement in hospital. (Paragraph 70.)

330. Hospital authorities should, in addition to beds needed for confinement and lying-in, provide as a priority, ante-natal beds for 20 per cent to 25 per cent of all confinements in their areas. These beds should be reserved solely for ante-natal patients. (Paragraph 71.)

331. Experience in this country justifies adherence to a period of ten days as the normal (not average) length of stay in hospital after delivery. (Paragraph 81.)

332. In some areas additional hospital maternity beds will be required and it must be left to the hospital authorities to decide what provision will require to be made in the light of their own local needs. (Paragraph 83.)

333. The local health authority and the patient's family doctor should, with the patient's consent, be informed by the hospital authority of the date on which she is to be discharged, irrespective of the time she has spent in hospital. (Paragraph 85.)

334. The Central Midwives Board might consider amending their Rules to reduce the minimum of the lying-in period defined therein from fourteen to ten days. (Paragraph 86.)

335. The amount of the home confinement grant should periodically be reviewed. (Paragraph 89.)

CHAPTER 6. THE WORK OF MIDWIVES

336. Any widespread attempt at present to compel domiciliary midwives to work in hospitals might disrupt the domiciliary nursing services. We believe that interchange between hospital and domiciliary midwives might become acceptable to midwives if it were made a normal condition of service on recruitment to a joint service. (Paragraph 103.)

337. A midwife should be given every opportunity to participate in the maternity care of her patients to the fullest extent to which her skill and experience entitle her. (Paragraph 107.)

338. The term "maternity nurse", in as far as it is applied to a certified midwife, should be reserved for a midwife who has notified her intention to practise as a maternity nurse only. (Paragraphs 108 and 132.)

339. The views of the Central Health Services Council regarding the status of the superintendent midwife, commended by the Minister of Health to hospital authorities in 1954, should be implemented. (Paragraph 110.)

CHAPTER 7. MATERNITY SERVICES PROVIDED BY LOCAL HEALTH AUTHORITIES

340. The respective responsibilities of all those involved in maternity care should be understood and proper records should be maintained to ensure that co-ordination is achieved. (Paragraph 131 and Chapter 11.)

341. The general practitioner obstetrician should ultimately replace the local authority medical officer in providing maternity care in local authority ante-natal clinics. (Paragraph 147.)

342. The use of local health authority ante-natal clinics should, as far as general practitioners are concerned, be reserved for doctors on the obstetric list. (Paragraph 149.)

343. Local health authorities should continue to provide premises and facilities for ante-natal clinics without charge to general practitioner obstetricians and to hospital medical staff holding outlying hospital clinics. (Paragraph 150.)

344. An appointment system should be instituted in all ante-natal clinics. (Paragraph 151.)

345. Health education and mothercraft instruction should be available for all expectant mothers. Local health authorities should, as necessary, provide instructors in health education in their own clinics, in the surgeries of general practitioner obstetricians and in hospital clinics. (Paragraphs 155 and 156.)

346. The present priority dental service should continue to be provided. (Paragraph 163.)

347. The home help service should be substantially increased but it should continue to be available for maternity cases on the same financial basis on which it is provided for other users. (Paragraphs 167 and 168.)

348. A Maternity Aid service, similar to that in Holland, would be a valuable supplement to the home help service. (Paragraph 170.)

CHAPTER 8. MATERNITY MEDICAL SERVICES PROVIDED BY GENERAL PRACTITIONERS

349. The practice of obstetrics requires special skill and experience. There is not enough domiciliary maternity work available to enable every general practitioner to obtain and maintain the necessary standard of skill. (Paragraph 192.)

350. The obstetric list should be continued. More uniform criteria should be applied for admission to and retention on it. (Paragraphs 193 to 197.)

351. A six months' resident appointment in an obstetric unit under the control of a consultant obstetrician should be the normal criterion for admission to the obstetric list. (Paragraph 195.)

352. In order to remain on the obstetric list, which should be reviewed every three years, a doctor should, over the preceding period of three years, have had at least 60 complete booked cases of which he should have attended deliveries of at least half. (Paragraph 196.)

353. Local obstetric committees should continue. An appeals procedure should be adopted. (Paragraph 197.)

354. There should be a periodical review of the criteria for admission to and retention on the obstetric list. These criteria should be made mandatory on local obstetric committees. (Paragraph 198.)

355. The present obstetric list should be accepted and should be reviewed at the end of three years. (Paragraph 201.)

356. Payment for maternity medical services should be for the exercise of special skill and experience as recognised by a doctor's inclusion in the obstetric list and such payment should be made only to doctors on the obstetric list. (Paragraph 202.)

357. Except in the circumstances mentioned in paragraph 205 a general practitioner obstetrician who undertakes to provide maternity medical services should receive the full fee even if the patient is subsequently transferred to hospital. (Paragraph 204.)

358. Medical aid fees, at present paid by local health authorities, should be paid by the authorities responsible for the payment of fees for maternity medical services. (Paragraph 207.)

359. We accept the advice set out in the memorandum on "Ante-natal Care Related to Toxaemia". We consider that the general practitioner obstetrician should be present at the delivery whenever possible; that he should give any necessary care to the mother and child for a period of fourteen days after confinement; and that a post-natal examination should be carried out as near as may be to six weeks after delivery. (Paragraphs 211 to 213.)

360. A general practitioner obstetrician and a midwife should be booked for every domiciliary confinement and there should be close co-operation between them. (Paragraphs 129 and 216.)

CHAPTER 9. MATERNITY SERVICES PROVIDED BY HOSPITAL AUTHORITIES

361. After lying-in beds have been allocated to patients in the priority groups, including patients with social needs and those requiring emergency admission, any remaining beds might then be allocated on a "first come, first served" basis. (Paragraph 224.)

362. Although it is preferable for a patient to be referred to hospital by her doctor a hospital should be able to book a patient who applies directly to them for admission. (Paragraph 225.)

363. An efficient appointment system should be adopted by all ante-natal clinics and prompt measures should be taken to follow up those who fail to attend. Hospitals should endeavour to make every use of both the local health authority staff and general practitioners to carry out this for them. (Paragraph 229.)

364. Hospital authorities should provide, as a priority, ante-natal beds for some 20 per cent to 25 per cent of all confinements in the country as a whole. These beds should be reserved solely for ante-natal patients. (Paragraph 231.)

365. Maternity hospitals should be organised in self-contained units of such a size that one sister can be in charge of both lying-in and labour wards and, if possible of ante-natal beds as well. (Paragraph 233.)

366. Every attention should be paid in hospital to the mental and physical care and well-being of women during pregnancy and childbirth. (Paragraph 234.)

367. Premature baby units, with adequate space and sufficient in number to cover the whole country, should be provided. (Paragraph 238.)

368. There should be sufficient "flying squads" to cover the country as a whole; they should be properly staffed and adequate transport should be available. Equipment for resuscitation should be kept in local hospitals and should be available to general practitioner obstetricians pending the arrival of the flying squads. (Paragraph 245.)

369. Local health authorities and general practitioner obstetricians should do all they can to co-operate with teaching hospitals in maintaining and extending facilities for training medical students in domiciliary midwifery. (Paragraph 247.)

370. The extra lying-in beds required to enable the hospital confinement rate to be raised to the suggested average of 70 per cent of all confinements should, where possible, be general practitioner beds. (Paragraph 258.)

371. General practitioner maternity beds are best situated within, or very close to, consultant maternity hospitals or general hospitals with maternity departments. A consultant obstetrician should have overall responsibility for supervision of general practitioner maternity beds. (Paragraph 258.)

372. All general practitioner obstetricians should have access to general practitioner maternity beds. (Paragraph 258.)

373. The use of general practitioner maternity beds should be limited to general practitioner obstetricians. (Paragraph 259.)

374. General practitioner maternity beds should be reserved for normal cases. (Paragraph 260.)

375. A representative panel should be set up for each general practitioner maternity unit to deal with all bookings. (Paragraph 261.)

CHAPTER 10. A COMBINED OR SEPARATE MATERNITY SERVICE?

376. At present the tripartite structure of the maternity service should be retained. It would not be practicable to transfer the maternity service alone to hospital control when all other health services remain under the tripartite structure. (Paragraph 293.)

377. Measures need to be taken to improve the co-ordination and the co-operation between the three branches of the maternity service. (Paragraph 299.)

378. There should be a firm link between the general practitioner obstetrician and the hospital. To strengthen this link fees for maternity medical services should be paid to general practitioner obstetricians by the hospital authorities. (Paragraph 299.)

379. Those local authorities, to whom local health authority functions are delegated under the provisions of the Local Government Act, 1958, who find it difficult because of the small number of domiciliary confinements to maintain an economical domiciliary midwifery service, might make arrangements for this service to be provided by the local Hospital Management Committees. (Paragraphs 117 and 300.)

CHAPTER 11. CO-ORDINATION ARRANGEMENTS

380. Local maternity liaison committees with a professional membership should be formed to ensure that local provisions for maternity care are utilised to the best advantage. (Paragraphs 310 and 311.)

381. Local clinical meetings should be encouraged so that all persons in an area responsible for carrying out maternity care can discuss the clinical aspects of maternity cases. (Paragraph 314.)

382. The publication of clinical reports by the hospital authorities should be encouraged and, with the co-operation of the local authorities, extended to cover the domiciliary midwifery service. (Paragraph 315.)

383. A standard co-operation card should be provided for use on a national basis. (Paragraph 316.)

384. Arrangements for the exchange of information between the various individuals carrying out maternity care need to be strengthened and we have indicated in paragraphs 319 to 324 and in Appendix VIII the arrangements which should be adopted. (Paragraphs 319 to 324.)

Signed CRANBROOK, *Chairman*

ARTHUR BEAUCHAMP

G. F. GIBBERD

E. B. GIBSON

W. V. HOWELLS

JEAN M. MACKINTOSH

H. JORDAN MALKIN

ELIZABETH PAKENHAM

V. SHAND

J. FOREST SMITH

MARY WILLIAMS

DAPHNE WILSON

ROMA N. CHAMBERLAIN } *Joint Secretaries*
S. GORDON MACKENZIE }

Date 27th November, 1958.

APPENDIX I

ORGANISATIONS AND PERSONS INVITED TO GIVE EVIDENCE

- *Association of Hospital Management Committees.
- *Association of Hospital Matrons.
- *Association of Municipal Corporations.
- *Association of Supervisors of Midwives.
- Association of Welsh Executive Councils.
- Baptist Union of Great Britain and Ireland.
- *Brighton and Lewes Hospital Management Committee.
- *British Dental Association.
- *British Medical Association.
- *British Paediatric Association.
- *Catholic Women's League.
- *Central Midwives Board.
- *College of General Practitioners.
- *M. I. Cockson, D.(Obst.)R.C.O.G., D.C.H., M.M.S.A.
- *County Borough of Brighton.
- *County Councils Association.
- *W. G. Daynes, M.R.C.S., L.R.C.P. (oral evidence only).
- *Dental Group of the Society of Medical Officers of Health.
J. B. Ewen, M.D., D.P.H.
- *Executive Councils' Association (England).
T. B. Fitzgerald, F.R.C.S., M.R.C.O.G.
Institute of Almoners.
- *League of Jewish Women.
- *London County Council (L.C.C. and Metropolitan Boroughs' Standing Joint
Committee submitted evidence jointly).
London Executive Council.
London Obstetric Committee.
- *E. K. Macdonald, O.B.E., M.D., B.S., D.P.H.
- *Medical Practitioners' Union.
- *Medical Women's Federation.
- *Mothers' Union.
- *National Association for Maternal and Child Welfare.
- *National Birthday Trust Fund.
- *National Federation of Women's Institutes.
- *National Union of Townswomen's Guilds.
- *Portsmouth Group Hospital Management Committee.
- *Queen's Institute of District Nursing.
Birmingham Regional Hospital Board.
- *East Anglian Regional Hospital Board.
Leeds Regional Hospital Board.
- *Liverpool Regional Hospital Board.
Manchester Regional Hospital Board.
- *Newcastle Regional Hospital Board.
North East Metropolitan Regional Hospital Board.
- *North West Metropolitan Regional Hospital Board.
Oxford Regional Hospital Board.

* These also gave oral evidence.

Sheffield Regional Hospital Board.
 South East Metropolitan Regional Hospital Board.
 South West Metropolitan Regional Hospital Board.
 South Western Regional Hospital Board.
 Welsh Regional Hospital Board.
 *Royal College of Midwives.
 *Royal College of Nursing.
 *Royal College of Obstetricians and Gynaecologists.
 *Salvation Army.
 *Society of Medical Officers of Health.
 *Teaching Hospitals Association.
 *C. F. Turner, M.B., Ch.B., M.R.C.S., L.R.C.P.
 Union of Catholic Mothers.
 *Women Public Health Officers' Association.

ORGANISATIONS AND PERSONS WHO GAVE EVIDENCE IN RESPONSE TO THE GENERAL PRESS NOTICE

Mr. P. R. Allen.
 M. Allerhand, M.D.
 Stephen Blaxland, B.M., B.Ch.
 David Blend, M.B., B.S.
 Mrs. C. W. Booth.
 W. G. Booth, M.D., B.S., D.P.H.
 Mrs. Prunella Briance.
 Mr. C. N. Burkett.
 Mr. E. G. Burt.
 Board of Governors of Charing Cross Hospital.
 Central Council for Health Education.
 Chartered Society of Physiotherapy.
 *Mr. John Chillman.
 Communist Party.
 *County Council of Middlesex.
 Mr. L. C. Cooper.
 Katharina Dalton, M.R.C.S., L.R.C.P.
 Dorset County Nursing Association.
 *A. Elliott, M.D., D.P.H.
 Mrs. Jean English.
 *Fellowship for Freedom in Medicine (Ltd.).
 Mr. Denzil Freeth, M.P.
 *J. F. Galloway, M.D., D.P.M., D.P.H., and Abigail Lesslie, M.B., Ch.B., D.P.H.
 —jointly.
 L. W. Heffernan, M.D., F.R.C.S., D.(Obst.)R.C.O.G.
 H. I. Howard, M.R.C.S., L.R.C.P.
 Huddersfield Executive Council.
 Mrs. M. P. James.
 Helena Jessler, M.D., D.(Obst.)R.C.O.G.
 Mr. O. V. Jones.
 Kent and Canterbury Executive Council.
 Mrs. R. Keys, B.A. (Hons.)
 Board of Governors of Kings College Hospital.
 Lambeth Group Hospital Management Committee.

* These also gave oral evidence.

- Lincoln and District Obstetric Advisory Committee.
- *Manchester City Council.
 - Manchester Professional Conference on Ante-natal Care.
J. C. Miller, F.R.C.S., M.R.C.O.G.
 - Mrs. D. Money.
 - Mrs. A. Morris.
 - National Assembly of Women.
 - *National Baby Welfare Council.
 - *National Council of Women of Great Britain.
 - *Natural Childbirth Association of Great Britain.
T. Alun Phillips, M.D., D.P.H.
 - Board of Governors of Queen Charlotte's and Chelsea Hospitals.
Mrs. P. Rice.
 - J. G. Rider, M.B., Ch.B., D.(Obst.)R.C.O.G.
 - *Royal Medico-Psychological Association.
Sheffield Local Medical Committee.
Mrs. V. Shannon, S.R.N.
 - *Joseph Sluglett, M.B., Ch.B. and Sarah Walker, M.D., D.P.H.—jointly.
Mrs. Margaret Stacey.
 - Stoke-on-Trent Executive Council.
Miss J. Tarttlin.
 - Tavistock Clinic.
 - Mrs. B. M. Taylor.
 - Mrs. M. P. Taylor.
 - Mrs. M. J. Tyson.
 - Mrs. Unwin.
 - Board of Governors of The United Manchester Hospitals.
Gerald C. Watmough, M.R.C.S., L.R.C.P.
 - Westmorland Advisory Obstetric Committee.
 - *Women's Co-operative Guild.

* These also gave oral evidence.

APPENDIX II

PERSONAL

MINISTRY OF HEALTH,
SAVILE ROW,
LONDON, W.1.

25th May, 1956.

Dear Sir/Madam,

Attached to this letter is a copy of a memorandum on ante-natal care embodying advice from the Standing Maternity and Midwifery Advisory Committee which has been endorsed by the Central Health Services Council. The considerations raised by this memorandum are largely professional and the Minister considers that as a preliminary to any administrative action which may be called for to give effect to the Advisory Committee's recommendations the memorandum ought to be discussed locally at hospital group level between professional representatives of the three parts of the National Health Service involved, i.e., the hospital and specialist service, the local health authority services and the general practitioners. Consideration has been given in consultation with the medical organisations to the best means of arranging these local discussions and the conclusion has been reached that they might most appropriately be initiated by the chairmen of Boards of Governors and Hospital Management Committees whose groups include hospitals with substantial maternity units or alternatively, as may be agreed locally, by the Chairman of the Liaison Committee between the three branches of the service, where one exists, or of the Hospital Group Medical Advisory Committee.

What is in mind is that the medical issues raised by the memorandum should, in the first instance, be fully discussed between the professional representatives who should report to the administrative bodies concerned any conclusions reached at the meeting which have administrative implications so that consideration may be given to any administrative action needed to give effect to them.

The procedure suggested is that the Chairman of the Board of Governors or Hospital Management Committee (or the Chairman of either of the committees mentioned in paragraph 1 where it has been agreed that he should assume responsibility for arranging the meeting) should arrange and summon the meeting, inviting the local professional representatives from the hospital service, the local health authorities and the local medical committees for the area served by the Board of Governors or Hospital Management Committee. The meeting would be restricted to professional representatives. The convening Chairman would start the proceedings but the meeting would elect its own chairman for the subsequent discussion. A note would be kept of the conclusions reached and copies would be sent to all members present. It would be for those present to take any further action, e.g. by raising any point requiring administrative action with the administrative bodies concerned, who in turn would inform the Department of any points requiring central consideration.

The agenda for the meeting should, it is thought, include the following points:

1. Any points for discussion on the actual content of the memorandum.

2. The part to be played by hospital ante-natal clinic, general practitioner, midwife and local authority ante-natal clinic in the ante-natal care of:—

- (a) The patient booked for admission to hospital under a consultant obstetrician.
- (b) The patient booked for admission to a general practitioner hospital unit.
- (c) The patient booked for home confinement under Maternity Medical Services.
- (d) The patient booked for home confinement by a midwife.

3. Any local arrangements needed to ensure a follow-up home visit of a patient who fails to attend for an ante-natal examination on the day appointed.

4. Arrangements for hospital treatment of early toxæmia.

5. Any necessary arrangements for blood tests during the ante-natal period.

6. Interchange of records.

7. Health education.

Chairmen of Boards of Governors and Hospital Management Committees who receive this letter are accordingly asked to discuss and agree with the Chairman of the Liaison Committee where one exists and of the Hospital Group Medical Advisory Committee who should accept responsibility for summoning the meeting, and for arranging for a note to be taken and circulated and the arrangements should then be put in hand with all speed. To facilitate this action, copies of this letter are enclosed. There may be areas where it would meet the general convenience for one meeting to cover more than one hospital group. The Senior Administrative Medical Officer of the Regional Hospital Board has been asked to consult the chairmen and other bodies interested with a view to ascertaining what arrangements would be most acceptable.

Copies of this letter and enclosure have been sent to the Local Health Authority, the Executive Council and the Local Medical Committee. Further copies of the Advisory Committee's memorandum will be sent on request.

Yours faithfully,

(Sgd.) E. RUSSELL-SMITH.

To Chairmen of H.M.Cs.

To Chairmen of Boards of Governors } with substantial maternity units.

**CENTRAL HEALTH SERVICES COUNCIL
STANDING MATERNITY AND MIDWIFERY
ADVISORY COMMITTEE
ANTE-NATAL CARE RELATED TO TOXAEMIA**

The present system of ante-natal care has been evolved during a long campaign to lower the high maternal mortality rate, which rightly caused such concern at the beginning of this century. The maternal mortality during this period has been lowered from 5 to under 1 per 1,000, but there still remains a substantial proportion of the present 300 or so maternal deaths each year which must be regarded as avoidable.

From the inquiry into the cause of maternal deaths it is already clear that toxæmia of pregnancy is the principal cause of avoidable maternal death in this country and it has been shown that toxæmia of pregnancy is also a major cause of stillbirths and neonatal death. In our present state of knowledge as to the cause of toxæmia, not all deaths from this cause are avoidable but many could be prevented by early detection and treatment. Inadequate ante-natal care, whether

due to failure of the patient to attend or to errors of judgment by her attendants, is the commonest avoidable factor contributing to maternal deaths in the study quoted.

Maternal mortality, stillbirth and neonatal death rates in various countries are as follows:

	<i>Maternal Mortality Rates</i>		<i>Stillbirth Rates</i>		<i>Neonatal Death Rates</i>	
	<i>1951</i>	<i>1953</i>	<i>1951</i>	<i>1953</i>	<i>1951</i>	<i>1953</i>
England and Wales ...	0.82	0.75	23.0	22.4	18.84	17.66
Scotland ...	1.09	0.92	26.6	24.8	22.3	19.3
New Zealand ...	0.69	—	17.69	18.75	16.2	14.04
Australia ...	1.05	0.62	18.63	17.01	17.5	16.64
Sweden ...	0.86	—	19.3	17.7	16.0	14.0
Netherlands ...	0.83	—	18.3	17.4	16.7	15.0

Little work has been done to relate the death of the child to maternal abnormalities. Dugald Baird (Aberdeen) analysing 1,008 "obstetric deaths" (i.e. stillbirths and first week neonatal deaths) according to maternal and foetal causes found about 20 per cent due to birth trauma, 20 per cent toxæmia and ante-partum hæmorrhage grouped together, 15 per cent foetal deformities and 33 per cent unexplained over half of which were premature. For stillbirths, however, some figures are obtainable as the international classification which includes maternal and foetal causes is used by a few countries. Thus in Scotland in 1953 of 2,308 stillbirths the main causes of foetal death were 20 per cent due to congenital abnormalities, 21 per cent toxæmia and ante-partum hæmorrhage grouped together, 14 per cent difficult labour and 11 per cent prolapse and torsion of the cord.

It is known, however, that stillbirths and neonatal deaths, or perinatal mortality, are much higher among the babies of toxæmic than of non-toxæmic mothers. Queen Charlotte's Maternity Hospital Report for 1951 shows that among 3,300 total deliveries the stillbirth rate was 23.5 per 1,000 total births, and the neonatal death rate 17 per 1,000 live births, whereas among 197 toxæmic mothers the stillbirth rate was 101 per 1,000 total births and the neonatal death rate 43.0 per 1,000 live births.

The perinatal mortality for the whole country has remained stationary for the last six years, and in fact the stillbirth rate rose to 24.0 in 1954. In Aberdeen, Baird and his co-workers; in Australia, the practice of the Women's Hospital, Crown Street, Sidney, described by Hamlin; and in New Zealand, Dawson, have shown that by more strict attention to ante-natal care a significant lowering of the incidence of eclampsia and over 50 per cent reduction in perinatal mortality rate can be obtained. All attribute their success to prompt detection of toxæmia through strict attention to ante-natal care followed by early admission to hospital and good sedation in severe pre-eclampsia. *This early recognition of toxæmia depends upon a routine designed to detect the smallest deviation from the normal*, for example, a rising blood pressure (usually a diastolic pressure of over 90 mm. of mercury) slight oedema or unduly rapid gain in weight. Albuminuria is considered a late sign indicating a serious risk of ante-partum hæmorrhage. The danger of intra-uterine death of the foetus is said to be in direct proportion to the height of the blood pressure and it is especially great when the systolic pressure remains at 160 mm. of mercury or more.

Heady and Morris in a recent series of papers have shown that certain groups of mothers are liable to have stillbirths and neonatal deaths. These include primiparae over the age of 30 and multiparae over the age of 40. Other workers have shown that there is an increasing danger to the mother and child after the

fourth confinement and in multiple pregnancies, also to those with a previous history of stillbirths and neonatal deaths who are very prone to repeat these misfortunes.

Dawson of New Zealand found that the average length of pregnancy for toxæmic mothers whose babies were stillborn or died soon after birth was 35.4 weeks, and this trend has been confirmed for this country by a survey into perinatal deaths in Bristol in 1948-50. Under the Maternity Medical Services the doctor must provide all necessary ante-natal care including an examination on booking and at 36 weeks. If these were the only examinations this important group of mothers would already have had their babies or have developed toxæmia without the possibility of detection. Most expectant mothers of course are examined much more frequently than this by the midwife who is also booked at a clinic or by the doctor himself, but the reference to the 36th week may well have obscured the importance of a medical examination at 30-32 weeks and careful intermediate examination thereafter.

PROPOSED ACTION

The time seems to have come when a concerted effort should be made by all three parts of the Maternity Service of the nation to tackle the problem of toxæmia of pregnancy. This will mean not only research by specialists in hospitals into the cause or causes and the prevention of toxæmia but also a thorough overhaul of the ante-natal care provided by the general practitioners, midwives, local authority clinics and hospitals.

It would seem appropriate that a review should be made here of what should be comprehended in good ante-natal care.

The pattern of supervision a mother is to receive should be mapped out at the first visit by the hospital staff, family doctor or midwife with whom the primary booking is made, although the plan is always subject to modification in the light of events. If more than one of these agencies or the local health authority clinic is involved, each should know clearly what part he or she is to play, and with whom and how responsibility is to be shared. Since the family doctor, whether booked or not, is almost certain to be called in an emergency, it is obviously necessary for him to know what arrangements are made, and others involved should recognise an obligation to keep him informed.

Personal history

The past medical obstetric history is one of the factors which will determine whether a patient should be confined in hospital. Any evidence of malnutrition, renal disease, heart disease, pulmonary tuberculosis or other serious illness in the past or any complications in a previous pregnancy are reasons for seeking a hospital booking. It is desirable where practical that all primiparae over the age of 30, all multiparae over the age of 40, mothers having their fourth or more confinement and those with multiple pregnancies as well as all cases of social need should have their babies in hospital. The importance of age, parity and multiple pregnancies in determining priority for a hospital bed is not always recognised. A policy on these general lines should be worked out in detail in each area and be clearly understood.

General Medical Examination

General assessment of the mother's health and nutrition is important especially as heart disease and anaemia still remain prominent contributory causes of maternal death. An X-ray examination of the chest is always advisable. Arrangements should be made for a thorough dental examination and early treatment either by the mother's own dentist or through the priority dental service provided by the local health authorities.

At the first visit any obstetric abnormalities should be noted and appropriate provision made for future treatment. The patient's basal blood pressure should be established during the early months of pregnancy and her weight noted. The urine should be tested, including a catheter specimen if there is a suspicion of albuminuria. Blood should be taken for examination.

At 30-32 weeks multiple pregnancies and some obstetric abnormalities will be detectable. Special attention should be paid at this stage to the blood pressure and any slight rise, abnormal weight gain, or other sign of toxæmia should lead to frequent and regular observations in order that treatment may be provided more promptly than has been customary in the past. The urine should, of course, be tested and albuminuria, if it occurs and is not related to other known disease, should be regarded as a late sign of toxæmia to be promptly and seriously treated. Maternal deaths have occurred because of failure to recognise the significance of the earliest signs or to take appropriate action when they have been noted.

The medical examination at 36 weeks, when other abnormalities likely to lead to difficulties in labour are commonly detected, should not be omitted. Birth trauma is still a high cause of perinatal mortality and conditions likely to lead to this might be foreseen and forestalled.

Between these examinations given by the family doctor, hospital or clinic medical staff, preferably with the midwife present, the midwife should see the mother at short intervals to check blood pressure, urine, and weight. Any mother showing signs of a rising blood pressure, excessive gain in weight, oedema or other abnormality should be referred to the appropriate doctor. It is advisable that the midwife should see her patient monthly until the 28th week, fortnightly until the 34th and 36th week and then weekly. It is essential that there should be a free interchange of information between midwife and doctor, and this should always be arranged as part of the plan for ante-natal care made at the time of booking.

Blood Testing

Blood examination is needed for four reasons:

- (a) To estimate the mother's haemoglobin (or even a full blood count) at booking and again at 30-32 weeks. An appreciable number of maternal deaths from ante or post-partum haemorrhage could have been prevented if pre-existing anaemia had been diagnosed early and treated adequately with laboratory control. Iron therapy is essential for about a quarter of expectant mothers, and probably many more would benefit. A haemoglobin level below 80 per cent suggests that treatment should be given.
- (b) To establish the mother's blood group, so that should gross ante or post-partum haemorrhage occur, the preliminaries to blood transfusion may be shortened.
- (c) To establish whether or not a mother is Rhesus negative. Tests for anti-bodies will be necessary later in pregnancy in Rhesus negative women and all women with anti-bodies should be confined in special centres with facilities for prompt exchange transfusions, i.e. within eight hours of birth, if the baby requires it. Infant deaths due to haemolytic disease of the newborn have risen from 410 in 1953 to 461 in 1954, and although this may be due to better diagnosis and certification, the majority could have been prevented by ante-natal detection and special care at birth.
- (d) To test for venereal disease so that any necessary treatment can be started as early as possible during pregnancy.

Ante-natal Records

It is essential that every doctor and every hospital or clinic providing ante-natal care should have an efficient filing system with good, clear, ante-natal records. Arrangements should be made to see that reports are exchanged between all concerned with the care of the mother both before and during labour. Hospitals which do not do their own ante-natal care should make certain they receive all information before the mother is admitted. In domiciliary practice there should be a free interchange of information between the doctor and midwife. One person, usually the midwife, should be responsible for the prompt follow-up at home of any woman who fails to attend the appointed time for ante-natal care since the reason may have been an abnormality, the serious nature of which is not understood by the patient. Hospitals should be ready to arrange for the family doctor or midwife, as may be agreed locally, to pay any necessary visits. This is manifestly of the greatest importance from the 30th week onwards.

Health Education and Preparation for Motherhood

Many mothers especially those having their first baby have been frightened by superstitious tales concerning childbirth and horrifying gossip from hospital or elsewhere. Sympathetic understanding and alleviation of their fears is a necessary part of good ante-natal care. Education should be given in general nutrition, hygiene and the course of labour, and the husband be helped to better understanding of the support he can give.

The gas and air or trilene apparatus for analgesia should be demonstrated to all mothers during pregnancy; a medical examination for fitness is of course necessary.

Hospitals which provide good physical care often are so pressed for time and space that the expectant mother may feel that her personal problems are not fully understood. Despite long waiting she may pass through a busy ante-natal clinic without the chance of discussing matters which, for her, may be serious worries. The numbers attending clinics should be small enough to allow the midwife and the doctor time to get to know and to talk to their patients as their counterparts in domiciliary work are able to do.

Many local authorities are extending their educational services. Hospitals or family doctors unable to undertake health education or to organise classes for relaxation and ante-natal exercises themselves may find it helpful to encourage their patients to use the facilities provided by local health authorities, whether at hospital or clinic.

Treatment Facilities

Once early toxæmia and other abnormalities have been recognised there are three essentials for a good service; a constant watch on all patients especially non-attenders; an adequate number of ante-natal beds so that treatment may be started as early as possible; and for the multipara a good home help service so that the mother, whether resting at home or admitted to hospital, is not worried about her home and children.

The number of ante-natal beds should bear a relation to the needs of the population served and not to the number of lying-in beds. The number of cases of toxæmia in similar communities is likely to be similar whether the area has many or few maternity beds. Some reallocation of beds may therefore be necessary. Better and careful selection of mothers for hospital confinement should be made as advised in the Ministry of Health circular, "Selection of Maternity Cases for Admission to Hospital". Where possible ante-natal patients should be given small wards where they can get essential rest and quiet.

Further progress in the reduction of maternal and perinatal mortality calls for even closer collaboration between all those who may be concerned with the care of the individual expectant mother, whether they be hospital consultants, general practitioners, midwives or other local authority staff. An assessment of her general and obstetrical condition, an early decision on the place of confinement, continuous supervision during pregnancy with special attention from the 30th week onwards should be provided through proper use of the existing services. Local liaison should secure their full use.

22nd September, 1955.

APPENDIX III

THE TOTAL NUMBER OF BIRTHS AND PERCENTAGE OF BIRTHS IN INSTITUTIONS IN COUNTIES AND COUNTY BOROUGHS IN ENGLAND AND WALES FOR THE YEARS 1950, 1953 AND 1957

Administrative County or County Borough	1950		1953		1957	
	Number of Births	Percentage of Births in Institutions	Number of Births	Percentage of Births in Institutions	Number of Births	Percentage of Births in Institutions
Bedford C.C. ...	4,798	61.8	4,948	61.7	5,941	59.8
Berks. C.C.	4,806	65.1	5,144	66.0	6,424	66.3
Bucks. C.C.	5,997	67.1	5,991	68.6	7,322	64.3
Cambridge C.C. ...	2,692	73.5	2,783	70.5	2,821	67.6
Chester C.C.	12,468	61.4	12,332	67.2	13,756	67.5
Cornwall C.C. ...	4,855	43.9	4,868	44.6	4,853	48.3
Cumberland C.C. ...	3,909	57.3	3,722	57.4	4,029	63.4
Derby C.C.	11,295	52.4	11,272	60.1	11,212	57.1
Devon C.C.	6,818	58.9	7,109	57.8	7,048	60.5
Dorset C.C.	4,003	57.2	4,216	64.5	4,342	62.9
Durham C.C.	16,504	33.3	16,910	49.7	17,926	53.2
Essex C.C.	23,893	62.0	24,967	64.4	27,019	63.1
Gloucester C.C. ...	7,017	61.5	7,125	64.1	7,706	64.1
Hereford C.C. ...	2,172	54.5	2,250	58.9	2,201	59.7
Hertford C.C. ...	9,442	72.9	10,101	68.1	12,686	62.4
Huntingdon C.C. ...	1,110	55.4	1,226	59.8	1,304	58.3
Isle of Ely C.C. ...	1,585	62.6	1,542	58.9	1,450	59.7
Isles of Scilly C.C.	26	92.3	47	87.2	23	95.7
Isle of Wight C.C.	1,276	47.3	1,244	59.3	1,207	54.9
Kent C.C.	23,083	60.9	23,268	65.1	27,252	59.9
Lancs. C.C.	31,653	62.2	31,064	69.3	34,527	67.8
Leicester C.C.	5,817	56.4	5,604	58.1	6,292	58.1
Lincs. Parts of Holland C.C.	1,739	53.7	1,771	53.1	1,674	57.8
Lincs. Parts of Kesteven C.C.	2,217	49.8	2,173	59.1	2,152	66.3
Lincs. Parts of Lindsey C.C.	5,284	58.1	5,382	63.1	5,441	66.1
London C.C.	55,797	75.3	52,662	79.4	54,393	80.9
Middlesex C.C. ...	31,971	73.5	30,578	77.4	31,620	78.4
Norfolk C.C.	5,056	25.1	5,660	42.1	5,622	38.7
Northampton C.C. ...	2,921	33.0	4,262	58.4	4,783	64.3
Northumberland C.C. ...	7,409	61.7	7,341	68.9	7,873	69.8
Nottingham C.C. ...	9,144	44.6	8,879	44.9	9,519	46.5
Oxford C.C.	2,787	65.2	3,177	72.8	3,606	74.4
Rutland C.C.	325	54.5	426	54.0	427	78.2
Salop C.C.	4,819	58.2	4,724	56.2	4,684	59.1
Soke of Peterborough C.C.	1,357	80.6	1,035	63.4	1,255	61.7
Somerset C.C.	7,330	58.8	7,040	66.9	7,417	69.4
Southampton C.C. ...	10,536	60.7	11,239	65.5	12,464	66.5
Stafford C.C.	14,105	39.7	14,132	48.2	15,771	53.3
Suffolk East C.C. ...	3,348	38.9	3,122	41.6	3,330	47.0

Administrative County or County Borough	Number of Births	Percentage of Births in Insti- tutions	Number of Births	Percentage of Births in Insti- tutions	Number of Births	Percentage of Births in Insti- tutions
	1950		1953		1957	
Suffolk West C.C. ...	1,978	63.5	1,865	57.7	1,868	58.4
Surrey C.C. ...	19,366	81.9	18,496	78.0	19,995	74.5
Sussex East C.C. ...	4,565	66.0	4,062	65.4	4,285	67.9
Sussex West C.C. ...	4,478	61.5	4,355	59.2	5,401	58.5
Warwick C.C. ...	7,847	64.4	8,274	66.6	9,785	63.9
Westmorland C.C. ...	1,175	73.4	989	78.2	1,103	85.7
Wilts. C.C. ...	6,251	61.4	6,695	65.0	7,004	63.3
Worcester C.C. ...	5,221	42.6	6,355	58.9	6,781	66.8
Yorks. E.R. C.C. ...	3,243	62.7	3,328	67.4	3,363	71.6
Yorks. N.R. C.C. ...	6,123	50.7	6,407	61.5	6,534	63.0
Yorks. W.R. C.C. ...	26,358	53.2	25,764	59.2	27,544	59.0
Barnsley C.B. ...	1,484	68.9	1,406	67.0	1,335	60.3
Barrow in Furness C.B. ...	1,292	59.1	1,232	63.7	990	69.4
Bath C.B. ...	1,170	87.0	1,155	86.3	1,145	85.9
Birkenhead C.B. ...	2,848	62.4	2,677	66.1	2,634	68.4
Birmingham C.B. ...	19,277	55.9	19,012	64.0	19,322	66.4
Blackburn C.B. ...	1,594	61.5	1,475	74.2	1,462	61.4
Blackpool C.B. ...	1,726	80.6	1,656	77.7	1,784	79.1
Bolton C.B. ...	2,587	77.1	2,490	76.5	2,423	83.3
Bootle C.B. ...	1,656	70.4	1,705	62.5	1,947	67.1
Bournemouth C.B. ...	1,722	73.5	1,683	70.2	1,698	69.1
Bradford C.B. ...	5,237	57.8	4,752	53.8	5,080	56.4
Brighton C.B. ...	2,222	78.9	2,005	75.2	2,180	72.4
Bristol C.B. ...	8,024	72.2	7,926	75.4	7,256	76.1
Burnley C.B. ...	1,383	53.8	1,233	60.1	1,296	60.9
Burton-on-Trent C.B. ...	925	59.1	899	67.7	914	72.2
Bury C.B. ...	805	69.6	733	72.4	910	76.8
Canterbury C.B. ...	452	48.9	469	51.0	474	47.7
Carlisle C.B. ...	1,104	83.5	1,106	74.1	1,226	77.7
Chester C.B. ...	807	68.8	807	66.5	1,016	66.6
C Coventry C.B. ...	3,651	42.3	3,687	47.7	4,949	47.2
Croydon C.B. ...	4,197	70.7	3,503	66.4	3,526	67.6
Darlington C.B. ...	1,367	67.7	1,328	73.2	1,357	74.6
Derby C.B. ...	2,248	65.1	2,205	69.3	2,132	64.8
Dewsbury C.B. ...	954	78.0	905	79.1	954	76.2
Doncaster C.B. ...	1,410	59.2	1,317	57.4	1,408	60.0
Dudley C.B. ...	1,089	48.4	1,039	48.7	997	53.9
East Ham C.B. ...	1,845	72.9	1,687	82.3	1,760	84.7
Eastbourne C.B. ...	725	72.1	640	84.1	599	84.0
Exeter C.B. ...	1,152	53.1	1,146	60.9	1,195	61.8
Gateshead C.B. ...	2,097	54.7	1,962	56.9	2,076	58.0
Gloucester C.B. ...	1,144	56.4	1,143	53.8	1,161	47.8
Great Yarmouth C.B. ...	829	40.8	764	34.4	789	36.2
Grimsby C.B. ...	1,763	53.4	1,668	61.6	1,875	59.8
Hallifax C.B. ...	1,596	68.5	1,452	70.6	1,529	62.1
Hastings C.B. ...	905	72.4	764	76.8	711	78.6
Huddersfield C.B. ...	1,955	87.0	1,816	87.8	1,971	85.1
Ipswich C.B. ...	1,815	38.0	1,893	46.2	1,977	45.1
Kingston-upon-Hull C.B. ...	5,792	37.9	5,852	48.4	5,690	53.6
Leeds C.B. ...	8,470	73.6	8,322	71.1	8,706	68.7

Administrative County or County Borough	Number of Births		Percent- age of Births in Insti- tutions		Number of Births		Percent- age of Births in Insti- tutions		Number of Births		Percent- age of Births in Insti- tutions	
	1950		1953		1957		1957					
Leicester C.B. ...	4,692	58.7	4,708	57.5	4,479	60.7						
Lincoln C.B. ...	1,026	58.2	1,089	63.3	1,158	59.3						
Liverpool C.B. ...	18,358	76.0	18,410	72.3	16,663	68.7						
Manchester C.B. ...	13,004	58.4	12,518	58.8	12,755	59.1						
Middlesbrough C.B. ...	3,181	41.7	3,285	38.8	3,344	32.7						
Newcastle-on-Tyne C.B. ...	5,051	47.2	5,067	55.1	5,150	59.6						
Northampton C.B. ...	2,568	83.6	2,676	86.3	1,576	76.8						
Norwich C.B. ...	2,507	62.3	2,286	58.0	1,847	48.2						
Nottingham C.B. ...	5,384	52.1	5,354	48.6	5,577	48.1						
Oldham C.B. ...	1,920	64.5	1,899	53.9	1,957	47.6						
Oxford C.B. ...	3,025	81.1	1,519	65.5	1,469	66.4						
Plymouth C.B. ...	3,642	57.1	3,685	49.1	3,701	48.7						
Portsmouth C.B. ...	3,761	66.8	3,833	57.4	3,619	60.6						
Preston C.B. ...	2,156	77.4	2,002	72.6	2,032	80.8						
Reading C.B. ...	1,869	69.1	1,700	64.6	1,849	55.2						
Rochdale C.B. ...	1,414	54.0	1,341	66.0	1,374	66.5						
Rotherham C.B. ...	1,475	50.0	1,354	50.9	1,446	48.1						
Salford C.B. ...	3,433	58.4	3,069	58.2	3,114	54.8						
Sheffield C.B. ...	8,083	57.0	7,840	60.8	7,707	59.0						
Smethwick C.B. ...	1,218	62.3	1,102	62.3	1,009	59.9						
Southampton C.B. ...	3,427	62.6	2,925	66.3	3,635	56.2						
Southend-on-Sea C.B. ...	2,224	68.8	2,031	64.3	2,085	64.3						
Southport C.B. ...	907	84.8	1,024	89.5	997	90.8						
South Shields C.B. ...	2,065	23.1	2,036	40.3	2,133	42.8						
Stockport C.B. ...	2,844	75.2	2,963	70.1	2,374	54.1						
Stoke-on-Trent C.B. ...	4,839	50.9	4,592	53.0	4,442	53.7						
Sunderland C.B. ...	4,131	46.0	4,083	43.1	4,092	40.2						
St. Helens C.B. ...	2,110	61.8	1,955	68.4	1,950	70.2						
Tynemouth C.B. ...	1,219	63.7	1,281	66.9	1,276	69.4						
Wakefield C.B. ...	1,035	64.3	959	52.9	970	52.7						
Wallasey C.B. ...	1,708	75.2	1,703	71.4	1,910	75.9						
Walsall C.B. ...	2,098	43.8	2,104	51.7	1,980	47.7						
Warrington C.B. ...	1,494	56.8	1,425	60.4	1,429	56.1						
West Bromwich C.B. ...	1,616	48.7	1,548	53.1	1,734	58.5						
West Ham C.B. ...	2,897	72.0	2,899	80.4	2,706	90.1						
West Hartlepool C.B. ...	1,420	68.3	1,456	66.9	1,683	66.6						
Wigan C.B. ...	1,446	40.9	1,401	48.4	1,311	55.6						
Wolverhampton C.B. ...	2,820	47.3	2,585	47.5	2,330	48.9						
Worcester C.B. ...	1,137	61.6	1,049	70.2	997	73.4						
York C.B. ...	2,109	66.0	1,563	59.6	1,655	63.8						

WALES

Anglesey C.C. ...	881	77.1	826	83.5	832	86.1
Brecon C.C. ...	881	53.5	880	61.4	843	68.0
Caernarvon C.C. ...	1,755	69.5	1,739	71.4	1,655	81.8
Cardigan C.C. ...	787	69.5	780	72.1	694	81.1
Carmarthen C.C. ...	2,531	55.9	2,505	60.6	2,409	66.9
Denbigh C.C. ...	2,875	77.9	2,626	80.4	2,656	82.5
Flint C.C. ...	2,596	67.6	2,278	71.7	2,283	77.6
Glamorgan C.C. ...	12,331	55.7	12,215	60.9	12,459	61.1
Merioneth C.C. ...	550	77.6	614	84.4	548	87.2

Administrative County or County Borough	Number of Births		Percentage of Births in Institutions		Number of Births		Percentage of Births in Institutions	
	1950		1953		1957			
Monmouth C.C.	5,573	57.0	5,514	61.1	5,622	63.6		
Montgomery C.C.... ..	728	63.7	686	68.1	693	76.0		
Pembroke C.C.	1,521	42.0	1,585	58.8	1,555	62.2		
Radnor C.C.	271	49.4	266	65.4	288	77.8		
Cardiff C.B.	4,608	55.9	4,568	56.2	4,711	59.6		
Merthyr C.B.	1,111	67.3	1,015	69.3	1,019	74.0		
Newport C.B.	2,123	64.6	2,063	54.8	1,697	55.4		
Swansea C.B.	2,654	56.2	2,514	62.5	2,736	71.2		
ENGLAND	671,194	61.3	661,759	64.4	695,004	64.5		
WALES	43,776	59.9	42,674	63.7	42,700	67.0		
ENGLAND AND WALES ...	714,970	61.2	704,433	64.4	737,704	64.6		

APPENDIX IV

To all hospital authorities

NATIONAL HEALTH SERVICE

The Selection of Maternity Cases for Admission to Hospital

1. The Minister has received advice from the Standing Maternity and Midwifery Committee of the Central Health Services Council about the selection of maternity cases for admission to hospital. That advice which has been endorsed by the Central Health Services Council and with which the Minister is in full agreement is set out in this memorandum.

2. During the last twenty years there has been a progressive increase in the proportion of confinements taking place in hospitals or maternity homes. The increase was accelerated during and immediately after the war, particularly in rural areas. The birth rate fell between 1947 and 1949, but although the actual number of births in hospital fell slightly the proportion rose sharply in this period. It is clear that the proportion of domiciliary confinements is determined partly by long-standing custom and partly by the degree of activity exhibited in providing beds for normal confinements. It is certainly not determined on medical grounds alone. Housing has some effect but some areas with relatively good housing have 20 per cent or less domiciliary confinements and others with much worse housing may have 70 per cent. Under the National Health Service the woman confined in hospital has all her treatment and attendance free, whereas the woman confined at home faces certain extra costs for attendance, bedding, equipment and fuel and provides her own food. The actual cost may not be large since a visiting midwife and medical attendance are free, but it is a factor in influencing the number of hospital confinements.

3. In most areas there is still a greater demand for maternity beds than hospitals can meet. Some hospitals are exercising selection; others are not. The criteria used in this selection vary widely and where little discrimination is shown hospitals are booking more than they should. It is known that many maternity units have an average stay of ten days or less and that means that women are often being sent home after the eighth day or earlier in the puerperium; and complaints have been received far too frequently of discharge from hospital even two or three days after confinement. On the other hand the number of domiciliary confinements has fallen rapidly and in consequence Local Health Authorities have found their domiciliary midwives under-employed. There has also been difficulty in arranging satisfactory Part II training for midwives because of the small number of cases.

4. There are still areas where the number of beds is insufficient for those who really need admission, but most areas have enough beds for the necessary cases, provided suitable selection is made. Without such selection, more beds would have to be provided when there are other more pressing demands on hospital resources, e.g. for the treatment of tuberculosis; and it would not be right to provide maternity beds for cases requiring them only as a convenience rather than those required for genuine needs. While there will be good reason to provide maternity beds in some special areas, therefore, the main problem is to ensure that those now available are used to the best advantage by a proper selection of cases.

5. It is suggested that priority in selecting applicants for booking hospital maternity beds should be accorded to (a) all cases in which there are medical or obstetric reasons in the widest sense of these terms, and (b) adverse social conditions, especially bad housing; (a) should not be regarded as necessarily including all primigravidae, though admittedly a large proportion should be admitted, and unquestionably most multiparae who have had four or more children would be within the group having medical reasons for admission.

6. It is hardly possible to define criteria for adverse social conditions. This is not solely a matter of housing ; the availability of attendance plays an important part and even more local custom. It is important, however, that the social factors should be assessed by those familiar with them and for this purpose the Medical Officer of Health of the Local Health Authority is best placed to advise on order of priority, following reports by his midwives or Health Visitors. His advice should always be sought on social factors.

7. It is essential that patients admitted for confinement should be retained for a sufficient period. In present circumstances the minimum period should be ten days, preferably extending to fourteen days, unless there are some exceptional reasons in a particular case why the patient may be discharged earlier to her home where adequate accommodation and attendance is known to be available.

8. The selection of bookings should be such that no more are accepted for a unit than can be retained for ten days or such longer period up to fourteen days as is practicable in local circumstances. Moreover, it is imperative that bookings should leave a sufficient margin of beds for emergencies. Where the proportion of institutional confinements is large, the reserve needed for emergencies is naturally small, but it is in just those areas where the shortage of beds is greatest that the margin for emergencies is most important. It should be recognised that a call to admit an emergency indicates at least some fear of insecurity in the mind of the attendant and such applications should normally be met without question. It is less difficult to forecast the appropriate number of bookings than might appear, for the proportion of emergencies does not fluctuate widely over the years and booking to a postulated 80 per cent bed occupation—or rather less where the proportion of domiciliary confinements is high or more where the proportion of domiciliary confinements is low—gives a reasonable margin of safety. The number of ante-natal beds required depends on the population served and is proportionately greater where the proportion of domiciliary confinements is high ; it is imperative that a sufficient number should be set aside to provide for the treatment of patients wherever they are to be confined.

9. It is not possible to lay down a proportion of births for which hospital or maternity home beds should be provided in all areas. But in general, hospital provision is required on medical or social grounds for about half the confinements. This proportion, however, may be exceeded in areas where social conditions require it or where the proportion of abnormal midwifery is high. The advice of the Local Health Authority should always be obtained as to the need for an increase in the number of beds, especially on social grounds, in any particular case.

Midwifery Practice by General Practitioners in Hospitals

10. Following discussions which he has had with representatives of the medical profession, the Minister wishes to remind Hospital Management Committees and Boards of Governors that it is desirable, wherever possible, that some maternity beds in suitable hospitals should be put at the disposal of general practitioners for the care of their own patients, subject always to the general policy about admission of patients indicated in this memorandum. Such beds would have to be excluded from those available for the training of pupil midwives in a midwifery training school, and it will be necessary for Committees and Boards to have regard to the needs of these schools in considering this matter.

MINISTRY OF HEALTH,

Savile Row,
London, W.1.

11th August, 1951

APPENDIX V

COMPARISON OF THE COST OF DOMICILIARY AND HOSPITAL CONFINEMENT

1. We have referred in paragraphs 88 and 89 of our Report to the difficulty of making reliable comparison between the costs of hospital and home confinements and to the widely held view that hospital confinements were less expensive for the mother but more expensive to public funds. This latter view was supported by the statistical returns for 1955-56 published jointly by the Institute of Municipal Treasurers and Accountants and the Society of County Treasurers which showed that the average cost of domiciliary midwifery for each maternity case attended, excluding administration costs, for all County Councils and County Boroughs in England and Wales was £16 5s. 0d. while the average cost of each maternity case in non-teaching hospitals, abstracted from information in the Hospital Costing Returns, was £35 7s. 9d. To the figure quoted for the cost of a domiciliary confinement must be added the amount of the home confinement grant (now £5) paid by the Ministry of Pensions and National Insurance and in most cases the cost of fees for maternity medical services (maximum of £7 7s. 0d.).

2. It has always been recognised that any comparison of the cost of confinements in hospitals (where there would be a large proportion of abnormal cases) and at home (where most would be normal) would be of limited value and there are many difficulties in comparing costing figures. There can be no standard cost or average cost without a standard service or an average maternity case. The service cannot be standard for all parts of the country because of variations in density of population, areas to be covered, housing and general social standards and the great variations in the medical and nursing requirements of each individual case. The costing returns are not precise instruments and differences of practice in compiling the statistics on which they are based as well as in the classification and inclusion or exclusion of various items of expenditure are inevitable however meticulous may be the attempts to achieve standardisation.

3. We have mentioned earlier in our Report the very varied methods by which a woman may receive ante-natal care either from the local health authority, the hospital authority or from her own doctor. Each variation in giving maternity care results in a variation in cost which cannot readily be assessed. The hospital cost per patient is of course affected by the length of stay: early discharge substantially reduces the cost per case to the hospital but it may throw additional cost on the local health authority's domiciliary service.

4. A number of factors have therefore to be borne in mind in considering costing figures:—

- (i) Domiciliary confinement costs may have to be *reduced* in so far as part of the local health authority's expenditure is in respect of ante-natal care for hospital booked patients, and of midwives visiting hospital booked patients discharged before the 14th day.
- (ii) Domiciliary confinement costs may have to be *increased* in respect of:
 - (a) Maternity Medical Service fees. The maximum fee is £7 7s. 0d. and in addition to this there might be mileage payments, and the cost of drugs. (Not all domiciliary confinements are attended by general practitioner obstetricians or by doctors at all, so the average would be less than £7 7s. 0d.)
 - (b) Maternity outfits
 - (c) Home confinement grant
 - (d) Home help
 - (e) Flying squad services

- (iii) Hospital confinement costs may have to be *reduced* in respect of ante-natal in-patient care provided for women subsequently delivered at home.
- (iv) Hospital confinement costs may have to be *increased* in respect of:
- (a) Ambulance services
 - (b) Maternity Medical Services (if the hospital is a general practitioner unit)
 - (c) Home help (but probably not so much as in the case of domiciliary confinements).

5. We obtained at our request from the Medical Officers of Health of East Suffolk County Council, Glamorgan County Council, Nottingham County Borough and Reading County Borough such estimates as they were able to make of the comparative costs in 1956 to public funds of domiciliary and hospital confinements in their own area. The information we received from them is, with their kind permission, summarised in the following tables:—

EAST SUFFOLK COUNTY COUNCIL

<i>Domiciliary</i>			<i>Hospital</i>		
	£	s. d.		£	s. d.
L.H.A. Midwifery ...	18	5 0	<i>Ipswich Maternity Hospital</i>		
L.H.A. Maternity pack ...	12	0	G.P. Unit ...	48	9 2
Maternity Medical Services ...	7	7 0			
G.P. mileage ...	5	0			
Home confinement grant ...	4	0 0	<i>Phyllis Memorial (Home Melton)</i>		
Maternity grant ...	10	0 0	G.P. Unit ...	52	9 10
	£40	9 0			
Home help ...	11	11 0	<i>Patrick Stead</i>		
	52	0 0	G.P. Unit (8 beds) ...	50	17 6
Less home help charges ...	3	11 0			
	48	9 0	<i>Ipswich and East Suffolk Hospital</i>		
			(Maternity Department) ...	43	17 4
Where no home help (85 per cent. of cases) ...	40	9 0			

GLAMORGAN COUNTY COUNCIL

<i>Domiciliary</i>			<i>Hospital: Barry Maternity Hospital (14 beds)</i>		
	£	s. d.		£	s. d.
Local health authority ...	26	1 6	Hospital ...	33	3 3
Maternity Medical Services ...	6	19 11	Ambulance ...	—	
Home confinement grant ...	4	0 0	Maternity grant ...	10	0 0
Maternity grant ...	10	0 0			
	£47	1 5		£43	3 3

NOTTINGHAM COUNTY BOROUGH

<i>Domiciliary</i>			<i>Hospital: Firs Maternity Hospital (40 beds)</i>		
	£	s. d.		£	s. d.
Local health authority ...	19	9 7	Hospital ...	35	9 6
Maternity Medical Services ...	4	11 11	Ambulance ...	1	11 3
Home confinement grant ...	4	0 0	Maternity Medical Services ...	12	7
Maternity grant ...	10	0 0	Maternity grant* ...	10	0 0
	£38	1 6		£47	13 4

* Plus 4 days domiciliary care.

READING COUNTY BOROUGH

<i>Domiciliary</i>				<i>Hospital: Deltwood G.P. Unit (17 beds)</i>			
		£	s. d.			£	s. d.
L.H.A. Midwifery ...	...	15	8 3	Hospital ...	...	25	15 0
Maternity Medical Services ...	...	7	7 0	Ambulance ...	...	—	—
Home help ...	...	6	6 7	Maternity Medical Services ...	...	7	7 0
Maternity grant ...	...	10	0 0	Maternity grant ...	...	10	0 0
Home confinement grant ...	...	4	0 0				
		£43	1 10			£43	2 0

=9 day stay.

<i>St. George's Hospital, Wallingford (17 beds)</i>							
Hospital ...	...	43	19 0				
Ambulance ...	...	—	—			
Maternity Medical Services ...	...	7	7 0				
Maternity grant ...	...	10	0 0				
		£61	6 0				

=11 day stay.

<i>Battle Hospital, Reading (50 beds)</i>							
Hospital ...	...	28	11 7				
Ambulance ...	...	—	—			
Maternity Medical Services ...	...	3	13 6				
Maternity grant ...	...	10	0 0				
		£42	5 1				

=10 day stay.

SOUTH WESTERN REGIONAL HOSPITAL BOARD SURVEY, 1955

6. We were very interested in the results of enquiries into the relative costs of domiciliary and hospital confinement made by a Committee set up, with assistance from the Nuffield Provincial Hospital Trust, by the South Western Regional Hospital Board in 1955. The Committee observed that a profitable comparison was extraordinarily difficult to make; firstly because it was almost impossible to obtain accurate figures of total costs, and secondly, because one was not comparing like and like. They thought that a domiciliary service offering an equal standard of comfort to the mother to that obtained in hospital would call for a great increase in the home help service. They concluded that the disparity in cost of domiciliary and hospital confinement was less than was generally supposed.

7. Each local health authority in the Region was asked the average cost to the authority of a domiciliary confinement. The highest figure was £24 12s. 6d. and the lowest £13 7s. 6d. The cost per case was lower in the cities than in the counties. The figures did not include the doctor's obstetric fee, the salaries of home helps or the cost of medical supplies issued through the Executive Councils. Separate costs were not obtainable for the maternity departments of general hospitals. The range within which the cost of maternity hospitals varied was great, from £26 10s. 1d. to £51 14s. 6d.

8. The costs were as follows :—

<i>Domiciliary</i>				<i>Hospital</i>			
Lowest							
Local Health Authority	...	£	s. d.	Hospital	...	£	s. d.
Maternity Medical Services...	...	13	7 6	Ambulance	...	26	10 1
Home confinement grant	...	7	7 0	Maternity grant	...	1	2 9
Maternity grant	...	4	0 0*		...	10	0 0
		10	0 0				
						£37	12 10
				Maternity Medical Services (if applicable)	...	7	7 0
		£34	14 6			£44	19 10
Highest							
Local Health Authority	...	24	12 6	Hospital	...	51	14 6
Maternity Medical Services...	...	7	7 0	Ambulance	...		14 8
Home confinement grant	...	4	0 0*	Maternity grant	...	10	0 0
Maternity grant	...	10	0 0				
						£62	9 2
				Maternity Medical Services (if applicable)	...	7	7 0
		£45	19 6			£69	16 2

9. The Board's Committee also considered the cost to the families, but as the arrival of a baby, particularly the first, was so notoriously subject to "conspicuous consumption" (or "keeping up with the Joneses"), they decided that the subject could not usefully be pursued by questionnaire. They did, however, enquire whether or not the home confinement grant of £4* was considered adequate and whether or not it influenced parental choice as between hospital and domiciliary confinement. More than half the 915 mothers who were questioned believed that they had not incurred additional expense. Few mothers gave saving of expense as the reason for preferring hospital confinement; and, even allowing for a reluctance to admit that it was, the investigators gained a strong impression that cost was not an important factor in the choice of hospital or domiciliary confinement.

* Now £5.

APPENDIX VI

List of boroughs and urban districts with a population of 60,000 or more as at 30th June, 1957. Those starred are in the Metropolitan area.

Only those outside the Metropolitan area are empowered, under the Local Government Act, 1958, to make delegation schemes for health and welfare functions.

ENGLAND

<i>County</i>	<i>County District</i>	<i>Estimated Population on 30th June, 1957</i>
Bedfordshire	Luton	115,900
Berkshire	—	—
Buckinghamshire	Slough	71,560
Cambridgeshire	Cambridge	91,980
Cheshire	—	—
Cornwall	—	—
Cumberland	—	—
Derbyshire	Chesterfield	67,200
Devonshire	—	—
Dorset	Poole	87,440
Durham	Stockton-on-Tees	76,410
Essex	Colchester	63,380
	Basildon	65,960
	Thurrock	104,200
	*Barking	75,070
	*Chigwell	60,420
	*Dagenham	114,400
	*Ilford	179,600
	*Leyton	99,670
	*Romford	111,800
	*Walthamstow	115,300
	*Wanstead and Woodford	60,970
	*Hornchurch	117,400
Gloucestershire	Cheltenham	68,230
Hampshire	Gosport	64,510
Hereford	—	—
Hertford	*Watford	73,050
Huntingdon	—	—
Isle of Ely	—	—
Isles of Scilly	—	—
Isle of Wight	—	—
Kent	Gillingham	79,280
	*Beckenham	75,440
	*Bexley	90,020
	*Bromley	65,550
	*Chislehurst and Sidcup	87,790
	*Orpington	72,170
Lancashire	Stretford	61,750
	Huyton-with-Roby	60,680
Leicestershire	—	—
Lincs. Holland	—	—

ENGLAND—continued

County	County District	Estimated Population on 30th June, 1957
Lincs. Kesteven ...	—	—
Lincs. Lindsey ...	—	—
London ...	—	—
Middlesex ...	*Acton ...	65,840
	*Baling ...	183,600
	*Edmonton ...	96,530
	*Enfield ...	109,200
	*Finchley ...	69,380
	*Harrow ...	215,000
	*Hendon ...	152,600
	*Heston and Isleworth ...	105,100
	*Hornsey ...	96,890
	*Southgate ...	71,250
	*Tottenham ...	119,300
	*Twickenham ...	103,600
	*Wembley ...	127,500
	*Willesden ...	174,100
	*Hayes and Harlington ...	67,190
	*Ruislip and Northwood ...	75,280
	*Uxbridge ...	60,780
Norfolk ...	—	—
Northamptonshire ...	—	—
Northumberland ...	—	—
Nottinghamshire ...	—	—
Oxfordshire ...	—	—
Rutland ...	—	—
Shropshire ...	—	—
Soke of Peterborough ...	—	—
Somerset ...	—	—
Staffordshire ...	Newcastle-under-Lyme ...	73,690
Suffolk East ...	—	—
Suffolk West ...	—	—
Surrey ...	*Epsom and Ewell ...	67,340
	*Mitcham ...	64,930
	*Surbiton ...	63,110
	*Sutton and Cheam ...	78,960
	*Carshalton ...	60,440
	*Coulston and Purley ...	67,830
	*Merton and Morden ...	71,090
Sussex East ...	Hove ...	69,620
Sussex West ...	Worthing ...	72,860
Warwickshire ...	Solihull ...	81,620
Westmorland ...	—	—
Wiltshire ...	Swindon ...	77,900
Worcestershire ...	—	—
Yorks. East Riding ...	—	—
Yorks. North Riding ...	—	—
Yorks. West Riding ...	—	—

WALES

Glamorganshire ...	Rhondda ...	106,900 (no others in Wales)
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APPENDIX VII

ENGLAND AND WALES

SUMMARY OF MATERNITY MEDICAL SERVICES PROVIDED

Part A: 1st January, 1957 to 31st December, 1957

Description of Services provided	By General Practitioner Obstetrician	By other G.P.s. to persons on their own lists	Total
1. (a) Number of cases in which complete maternity medical services provided	279,062	7,902	286,964
(b) Number of such cases in which the doctor providing the services was in attendance at the confinement	172,763	3,952	176,715
2. Number of cases in which Period I only provided	108,795	8,309	117,104
3. (a) Number of cases in which Period II only provided	7,609	236	7,845
(b) Number of such cases in which the doctor providing the services was in attendance at the confinement	4,100	100	4,200

Part B: Cases carried over from 1956 because they were not included in the 1956 return

1. (a) Number of cases in which complete maternity medical services provided	23,868	647	24,515
(b) Number of such cases in which the doctor providing the services was in attendance at the confinement	14,590	292	14,882
2. Number of cases in which Period I only provided	13,278	1,511	14,789
3. (a) Number of cases in which Period II only provided	829	19	848
(b) Number of such cases in which the doctor providing the services was in attendance at the confinement	487	9	496

APPENDIX VIII

SUMMARY OF RECOMMENDED ARRANGEMENTS FOR THE EXCHANGE OF INFORMATION BETWEEN PERSONS CONCERNED WITH MATERNITY CARE

A. In respect of patients booked for confinement in hospital

1. *Booking*

- (a) priority groups—the hospital will book these cases on its own initiative ;
- (b) social cases. The hospital will refer to the local health authority for written assessment of social conditions.

All information is supplied to the various bodies with the consent of the patient.

2. In all cases the hospital informs:

(i) the patient's family doctor of:

- (a) her booking ;
- (b) any abnormalities which arise during pregnancy ;
- (c) her failure to attend clinic if they wish him to contact her ;
- (d) her emergency admission to hospital ;
- (e) her discharge from hospital ;
- (f) any abnormalities found at the post-natal clinic.

(ii) the local health authority of:

- (a) her booking if they wish the local health authority to carry out health education ;
- (b) her failure to attend clinic ;
- (c) her discharge (if possible before she leaves).

In addition :

3. *Where the hospital delegates their responsibility for ante-natal care to a general practitioner obstetrician*

- (i) The hospital fills in the co-operation card stating clearly when they wish to see the patient again.
- (ii) The hospital informs the general practitioner obstetrician of the:
 - (a) patient's booking ;
 - (b) patient's discharge from hospital.

4. *Where the hospital delegates their responsibility for ante-natal care to a local health authority*

- (i) The hospital fills in the co-operation card stating clearly when they wish to see the patient again.

B. In respect of patients booked by a general practitioner obstetrician for confinement at home or in a general practitioner unit

1. The general practitioner obstetrician informs:

(i) the patient's family doctor:

- (a) when he books the patient ;
- (b) of any abnormalities which arise ;
- (c) if the patient is transferred to hospital ;
- (d) when the patient is discharged from his care.

- (ii) the local health authority that he has booked the patient to ensure that she receives health education and, if she is to have her baby at home, that she books a domiciliary midwife.

2. The general practitioner obstetrician fills in the co-operation card. (If he is doing ante-natal care only for the hospital—he should fill in the co-operation card and inform the hospital of any abnormalities which may arise.)

C. The procedure for the domiciliary midwife if the patient is booked for home confinement

The domiciliary midwife:

- (a) sends the patient to her family doctor to ensure that she books a general practitioner obstetrician;
- (b) ensures that the patient receives ante-natal care;
- (c) fills in the co-operation card;
- (d) ensures that the patient receives the necessary health education and other local authority services.

D. Procedure for the local health authority

Local health authority:

- (a) notifies the hospital in writing of the reasons for admission to hospital of social cases;
- (b) carries out any ante-natal care requested by the general practitioner obstetrician or hospital—and fills in the co-operation card;
- (c) follows up absentees from clinics for hospital, local authority or general practitioner obstetrician;
- (d) ensures that a health visitor or midwife, where appropriate, attends the patient after discharge from hospital.

E. Procedure for family doctor

The family doctor:

- (a) if his patient attends him in the first instance he ensures that she books with the general practitioner obstetrician and midwife or attends hospital;
- (b) if he is requested to do so follows-up absentees from clinic or sees that it is undertaken;
- (c) informs the general practitioner obstetrician or hospital of any infectious disease in the family.

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